Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), as construed by this Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and its progeny, completely preempts state-law claims by ERISA plan participants or beneficiaries who assert that a managed care company tortiously "failed to cover" (*i.e.*, pay for) medical care.

PARTIES TO THE PROCEEDINGS

Petitioner Aetna Health Inc. is the successor to Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc., both of which merged into Aetna Health Inc. In addition to the parties named in the caption, the following individuals and entities were parties in the consolidated cases below and are respondents in this Court. The following parties were plaintiffs-appellants below: Robert Roark; Robert Roark, on behalf of the estate of Gwen Roark. The following party was a plaintiff-appellant-cross-appellee in the court below: Ruby R. Calad. The following party was a plaintiff-cross-appellee in the court below: Walter Patrick Thorn. The following parties were defendants-appellees in the court below: Humana, Inc.; Humana Health Plan of Texas, Inc., d/b/a Humana Health Plan of Texas (Dallas), d/b/a Humana Health Plan of Texas (San Antonio), d/b/a Humana Health Plan of Texas (Corpus Christi); Humana HMO Texas, Inc.; Cigna Healthcare of Texas, Inc., d/b/a Cigna Corporation.

RULE 29.6 STATEMENT

Petitioner's parent company is Aetna Inc., a publicly traded company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Aetna Health Inc. (as successor to Aetna U.S. Healthcare of North Texas Inc. and Aetna U.S. Healthcare Inc., which were defendants below) respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.[1]

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, at 1a-29a) is reported at 307 F.3d 298 (5th Cir. 2002). The opinion and order of the United States District Court for the Northern District of Texas denying respondent Davila's motion to remand and dismissing the complaint with prejudice (App., *infra*, at 30a-35a) is unreported.

JURISDICTION

The district court had federal question jurisdiction over the plaintiffs' claims pursuant to 28 U.S.C. § 1331 and the complete preemption effected by 29 U.S.C. § 1132. The court of appeals had jurisdiction to review the final judgments of the district court pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered on September 17, 2002. The court of appeals denied Aetna's petition for rehearing and suggestion for rehearing en banc on April 15, 2003. App., *infra*, at 37a-39a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1). This proceeding draws into question the constitutionality of a state statute under the Supremacy Clause of the Constitution, and the notification required by this Court's Rule 29.4(c) has been transmitted to the Attorney General of Texas. Although the courts

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[1] A petition seeking review of a different aspect of the same consolidated judgment is pending as No. 02-1826.

below did not certify this issue pursuant to 28 U.S.C. § 2403(a), the Attorney General participated as *amicus curiae* in the court of appeals.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution, U.S. Const. art. VI, cl. 2, and the pertinent provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), and the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003 ("THCLA"), are set forth in the Appendix, *infra*, at 41a-63a.

STATEMENT OF THE CASE

1. Petitioner Aetna Health Inc. ("Aetna") operates a federally qualified health maintenance organization ("HMO"), which provides health services to its subscribers on a prepaid basis. Aetna contracts with employers and others to administer benefits available under plans established pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

Respondent Juan Davila receives health care benefits through an ERISA plan provided by his employer, Monitronics International, Inc. Aetna insures and administers benefits for the Monitronics Plan, including precertifying, on the plan's behalf, whether coverage is available under the terms of the plan that require a particular service or prescription drug to be "medically necessary" in order to be covered. The "Certificate of Coverage" for the Monitronics Plan expressly states that "*[f]or the purpose of coverage*, HMO [Aetna] may determine whether any benefit provided under the Certificate is Medically Necessary." App., *infra*, at 122a (emphasis added; boldface omitted)). The Certificate further emphasizes, in bold print, that "**THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT**

A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE." *Id.* at 107a. In other words, under the terms of the plan Aetna decides only whether the Monitronics Plan "covers" (*i.e.*, will pay for) a proposed treatment or service, not whether a participant or beneficiary actually receives that treatment or service.

2. In April 2000, Davila visited his primary care physician, Dr. Joseph Lopez, for treatment of discomfort associated with Davila's arthritis. Dr. Lopez prescribed the painkiller "Vioxx" to alleviate that discomfort. App., *infra*, at 4a. Under the terms of Davila's benefits plan, however, participants were ordinarily required to try an analogous but less expensive medication before Aetna could authorize payment for Vioxx. *Id.* at 4a-5a. On May 10, 2000, Aetna issued a benefits determination that so advised Dr. Lopez. Aetna's letter noted that as part of its "utilization review program," Davila's "benefit design require[d] precertification for" Vioxx. The letter also outlined the circumstances in which such precertification would be granted—none of which was then applicable to Davila. *Id.* at 80a.[2] "Based on the review of information submitted to us," the letter stated, "your request to authorize payment for the Formulary excluded medication has been denied." *Id.*

Aetna's benefits determination further noted that if Dr. Lopez or Davila wished "to take exception to this decision," either could "file a formal grievance with the HMO." App., *infra*, at 81a. The letter went on to advise Dr. Lopez of his statutory "right to review by an Independent Review Organi-

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[2] The letter specified that contraindication of other medications would have been a ground for precertification. App., *infra*, at 80a. There is neither allegation nor evidence in the record that Davila's physician asserted this ground.

zation (IRO) of adverse coverage determinations based on medical necessity," including the right to expedited IRO review if Davila's condition was life-threatening. *Id.* *See generally Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (discussing interaction between state laws providing IRO rights and ERISA).

Davila and Dr. Lopez did not exercise any of the remedies outlined in Aetna's benefits determination. Nor did Davila seek relief under Section 502 of ERISA, which entitles an ERISA plan participant or beneficiary to bring an action "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Instead, Davila began taking a different medication covered by Monitronics' ERISA plan. Several weeks later, Davila was diagnosed with bleeding ulcers, which required in-patient hospital care. App., *infra*, at 5a. Davila contended that this condition was caused by Aetna's determination that Davila's plan did not immediately cover a more expensive painkiller with a lower level of gastrointestinal toxicity. *Id.* at 4a-5a, 68a-69a.

3. Davila sued Aetna (then known as Aetna U.S. Healthcare of North Texas Inc. and its corporate parent Aetna U.S. Healthcare Inc.) in Texas state court under the Texas Health Care Liability Act ("THCLA"), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-.003. App., *infra*, at 68a-71a. Davila sought compensatory and punitive damages, alleging that Aetna had created a likelihood of substandard care by using a formulary (a list of prescription drugs) with progressive steps of drug coverage, and had acted negligently in its decision not to cover Vioxx from the beginning. *Id.* at 5a, 31a, 70a. The complaint averred that, despite Dr. Lopez's recommendations, petitioner "refused to provide Vioxx" (*id.* at 65a), and that accordingly it "failed to use ordinary care in influencing, controlling, participating in and making healthcare treatment decisions regarding [him] through its adherence to its prescription drug formulary policies." *Id.* at 68a-69a. With his complaint, Davila submitted an affidavit from Dr. Lopez, copies of medical studies concerning Vioxx's gastrointestinal toxicity, and a copy of Aetna's letter denying precertification for Vioxx.

Aetna removed the action to the U.S. District Court for the Northern District of Texas, asserting that Davila's claims are completely preempted by ERISA and thus removable under *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). App., *infra*, at 30a-31a, 82a-91a. Davila moved to remand, alleging a lack of subject matter jurisdiction. The district court held that under *Metropolitan Life*, Davila's claims must be recharacterized as stating federal questions under ERISA:

> What Plaintiff really challenges * * * is Defendants' determination regarding which particular drugs are covered under the plan and the circumstances of that coverage. The Court concludes that, distilled to its essence, Plaintiff's claim against Defendants concerns the administration of benefits under the plan * * *. As a result, his state-law claim is completely preempted by ERISA, federal-question jurisdiction exists, and removal was proper.

Id. at 34a. Because Davila declined to plead a claim under ERISA, the court dismissed Davila's complaint with prejudice for failure to state a claim upon which relief could be granted. *Id.* at 34a-35a.

4. A panel of the Fifth Circuit consolidated Davila's appeal with several other removed ERISA actions, including those of respondents Calad, Roark, and Thorn, and reversed.[3]

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[3] Calad, Roark, and Thorn are deemed respondents under this Court's Rule 12.6.

App., *infra*, at 1a-29a. The court recognized that federal courts have removal jurisdiction over state-law claims that are completely preempted by ERISA. It read the rule in *Metropolitan Life, Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and related cases, however, to be "a narrow one," stating that a claim is completely preempted by ERISA only if it "duplicates * * * an ERISA § 502(a) remedy." App., *infra*, at 9a, 20a. The court of appeals declined to make any inquiry into "whether the state law conflicts with or frustrates a congressional purpose." *Id.* at 9a. Instead, it confined its analysis to whether the THCLA "duplicate[d]" any of the nine causes of action enumerated in Section 502(a), stating that only "[i]f [respondents] could have brought their claims under ERISA § 502(a)" would their claims be completely preempted. *Id.*

The court proceeded to analyze whether respondents "could have asserted a claim that falls within" any of the various subsections of Section 502(a). App., *infra*, at 10a. The court did not examine whether the cause of action or the remedy created by THCLA *supplemented* the exclusive remedial scheme set out in Section 502(a), but only whether respondents' claims under that statute "duplicate[d]" one of the rights of action in the federal scheme. *Id.* at 9a; *see id.* at 20a (stating that "essentially, the test employed for 'complete preemption'" is that "States may not *duplicate* the causes of action listed in § 502(a)" (emphasis added)).

The court of appeals determined first that the THCLA claim did not precisely duplicate a beneficiary's right of action to secure compliance with the terms of the ERISA plan. App., *infra*, at 10a. Although Section 502(a)(3) allows a beneficiary to sue "to enforce any provisions of [ERISA] or the terms of the plan," the court of appeals held that the THCLA claims did not duplicate such a claim, because the state law made available a form of *relief*—"damages claims"—that ERISA does not. *See* App., *infra*, at 10a. The

court's analysis, which rested entirely on the unavailability of damages under ERISA, was confined to a single sentence: "Section 502(a)(3) indicates equitable remedies are generally available under ERISA; it includes only those categories of relief that were typically available in equity, *not the damages claims Calad and Davila bring*." *Id.* (emphasis added) (citation and internal quotation marks omitted).

The court of appeals applied the same duplication analysis, and used a similarly formal distinction between "contract" and "tort," to conclude that the THCLA claims did not precisely overlap with Section 502(a)(1)(B). App., *infra*, at 15a-20a. The court reasoned: "Section 502(a)(1)(B), we have held, creates a cause of action for breach of contract * * *. By contrast, Calad and Davila assert tort claims * * *." *Id.* at 16a. Because Davila was asserting a cause of action sounding in tort, the court reasoned, his action could not precisely "duplicate" a claim under Section 502(a)(1)(B). *See id.* at 16a-17a. Similarly, the court concluded that removal of respondent Roark's original complaint had been proper because that "complaint stated at least one cause of action completely preempted by § 502(a)": "Count Six of [that] original complaint alleges breach of contract." *Id.* at 22a, 23a. The court relied on this contract/tort distinction to distinguish an earlier circuit precedent—which it described as "on point," and in which the court had *upheld* removal based on complete preemption. *Id.* at 16a (citing *Dowden v. Blue Cross & Blue Shield, Inc.*, 126 F.3d 641 (5th Cir. 1997) (per curiam)); *see Dowden*, 126 F.3d at 643.[4] For the court

[4] "Like Calad and Davila," the court acknowledged, "Dowden claimed she was denied medically necessary treatment. But Dowden asserted a contract claim for contract damages; Calad and Davila assert a tort claim for tort damages. Calad and Davila are not seeking reimbursement for benefits denied them * * *." App., *infra*, at 17a.

of appeals, the distinction between contract and tort began and ended the analysis of whether respondents' claim "duplicate[d]" one under Section 502(a)(1)(B).

Having concluded that the state-law claims did not perfectly overlap with the causes of action included in Section 502(a), the court finally addressed this Court's decision in *Pilot Life* and Aetna's argument that the THCLA impermissibly supplemented Section 502(a)'s set of remedies. The Fifth Circuit conceded that "*Pilot Life* includes some expansive language that arguably support[ed]" preemption in this case. App., *infra*, at 19a. The panel concluded, however, that "the Supreme Court's most recent word on the matter, [*Rush Prudential*], indicates *Pilot Life* does not sweep so broadly." *Id.* The court reiterated that it would demand precise replication of a Section 502(a) cause of action before it would find complete preemption: under *Rush Prudential*, it concluded, the "narrow" rule of complete preemption applies only if States "duplicate the causes of action listed in ERISA § 502(a)." *Id.* at 20a.

The court also concluded that Davila's cause of action did not precisely replicate a claim that could be brought under ERISA § 502(a)(2). App., *infra*, at 12a-15a. The panel relied heavily on *Pegram v. Herdrich*, 530 U.S. 211 (2000), for the proposition that Davila could not sue his HMO under Section 502(a)(2). *See id.* at 12a-14a. In *Pegram*, this Court held that HMO patients cannot sue physician-owned HMOs for breach of fiduciary duty under Section 502(a)(2) based on it called "mixed eligibility and treatment decisions" by a treating physician. 530 U.S. at 228-31. Although the Fifth Circuit conceded that "*Pegram* did not decide the precise question before us," the court concluded nonetheless that "its holding is broad enough to apply here." App., *infra*, at 12a.

In light of its conclusion that Davila's claims did not precisely duplicate causes of action that could be brought under Sections 502(a)(3), 502(a)(2), or 502(a)(1)(B), the court

held that Davila's claims are not completely preempted and thus do not arise under federal law, as necessary to confer removal jurisdiction. The court therefore reversed the denial of Davila's remand motion. *See* App., *infra*, at 20a, 29a.

REASONS FOR GRANTING THE WRIT

By categorically exempting state tort actions from complete preemption, the Fifth Circuit's decision has created a conflict among the circuits that, if allowed to stand, will lead to the development of conflicting and overlapping state remedial schemes for ERISA benefits determinations. The decision below is in direct conflict with this Court's decision in *Pilot Life*, which unambiguously held that a tort claim that supplements the remedies provided by ERISA § 502 is indeed completely preempted, and with an unbroken string of this Court's subsequent decisions—all but one unanimous—that have consistently reaffirmed *Pilot Life*.

The Fifth Circuit, evidently influenced by this Court's analysis of "mixed" treatment and eligibility decisions in *Pegram v. Herdrich*, 530 U.S. 211 (2000), thought that *Pilot Life* can no longer be relied upon as resolving the very issue on which this Court ruled in that case: that a state tort action for damages represents an alternative enforcement scheme preempted by ERISA § 502(a). But *Pegram* was not a preemption ruling at all, as this Court itself noted (*id.* at 236-37), and this Court certainly did not so much as suggest that its analysis of the distinct issue in that case required reconsideration of *Pilot Life* and its progeny. Indeed, not only does the decision below usurp this Court's sole authority to overrule or modify its own decisions, it also diverges from the run of sister-circuit cases that recognize that the *Pilot Life* rule is alive and well. The decision below, by eliding binding precedent that is faithfully followed in a majority of other courts of appeals, has created a conflict on an important issue that is ripe for resolution by this Court.

I. The Fifth Circuit's Decision Conflicts Directly With An Unbroken Sequence Of Decisions By This Court

ERISA is a "'comprehensive and reticulated statute'" that sets out an exclusive, nationally uniform framework for regulating the administration of employee benefit plans. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980)). A critical element of that finely balanced regulatory scheme is the remedial provision, ERISA § 502(a), which provides the full array of remedies that Congress deemed appropriate for plans and their participants and beneficiaries. As this Court repeatedly has held, the rights of action that Section 502(a) provides are exclusive in every way, and the harmony of the statutory scheme forecloses any effort by States either to add to or to detract from the causes of action provided by Section 502(a).

1. Sixteen years ago in *Pilot Life*, this Court first confirmed the exclusivity of Section 502(a) and the impermissibility of state attempts to supplement it. When the Pilot Life Insurance Company terminated an insured's disability benefits purportedly guaranteed under an ERISA plan, the insured filed suit not under ERISA § 502(a), but under Mississippi tort law. 481 U.S. at 43. As in this case, the plaintiff contended that the insurer's benefits decision failed to comport with a state standard of reasonableness and gave rise to liability for the tort of "bad faith." *See id.* at 43, 49-50. And as in this case, the Fifth Circuit held that his tort action was not preempted by ERISA. *See id.* at 44.

This Court unanimously reversed, rejecting the plaintiff's argument that his cause of action for bad faith was saved from preemption by ERISA § 514(b)(2)(A) as a permissible regulation of insurance. The Court reached that conclusion by examining the entire ERISA statutory framework and the role that Section 502(a)'s carefully enumerated remedies play within it. 481 U.S. at 51-52. As the Court

recognized, the structural integrity of ERISA depends upon the exclusivity of Section 502(a)'s enforcement remedies:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted * * * provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."

Id. at 54 (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (alteration and emphasis in original). The Mississippi common law action for bad faith—which, for example, permits recovery of punitive damages where ERISA does not—would have upset this balance if applied to a benefits decision under ERISA. *See id.* at 50, 54. With this factor weighing heavily, the Court held the tort claim preempted. *Id.* at 57.

That same day, in another unanimous decision, *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), this Court held that Section 502(a)'s preemptive power is sufficient to confer federal jurisdiction over all claims within its ambit, including claims pleaded exclusively under state law. Taylor asserted that he was disabled, and when his disability insurer denied his claims for benefits, he sued in state court, asserting contract and tort claims under Michigan law. The defendants removed the action to federal court, where they

prevailed on the merits. The court of appeals ordered a remand to state court on the ground that the suit presented no federal question. *Id.* at 61-62. This Court unanimously reversed that holding. *Pilot Life* had established that "a suit by a beneficiary to recover benefits from a covered plan" necessarily "falls directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63 (citing *Pilot Life*, 481 U.S. at 56). Taylor had sought an award of benefits *and* damages arising from their denial; ERISA therefore plainly preempted his Michigan law claims under *Pilot Life*. *Id.*

Moreover, this Court held, *Pilot Life* preemption was sufficient to confer removal jurisdiction. Section 502(a) preempts so completely and so strongly that it sweeps into federal court any action within its ambit; because it has displaced any parallel state cause of action, any suit touching the same subject matter becomes a Section 502(a) claim. Taylor's complaint had pleaded only state-law causes of action; the Court held, however, that because those claims were within the scope of Section 502(a), they were "necessarily federal in character" and sufficient to invoke federal "arising under" jurisdiction. *Metropolitan Life*, 481 U.S. at 67.

Taken together, *Pilot Life* and *Metropolitan Life* unambiguously refute both the "duplication" analysis and the contract/tort distinction on which the Fifth Circuit sought to rest its holding in this case. Both decisions confirm that *all supplemental state remedies* for allegedly improper benefits administration—not just "duplicative" ones, and certainly not just those that are styled "contract" remedies or seek equitable relief—alter the balance that Congress established in Section 502(a).

First, these decisions spell out that Section 502(a) *as a whole* has preemptive force, independent of any of its individual causes of action, because Congress intended it to be exclusive. *Metropolitan Life*, 481 U.S. at 63; *Pilot Life*, 481

U.S. at 57. Allowing States to add to or vary Section 502(a)'s careful balance conflicts with that congressional purpose. *Pilot Life*, 481 U.S. at 54. The court of appeals disregarded this aspect of *Pilot Life* and *Metropolitan Life*, *see* App., *infra*, at 9a (stating that "[w]e do not ask whether the state law conflicts with or frustrates a federal purpose"), and instead focused only on duplication of the individual causes of action. The basis for the preemption holding of *Pilot Life* and *Metropolitan Life*, however, was the exclusivity of Section 502(a) *as a whole*.

Second, by their very facts, both decisions make crystal clear that state-law tort claims enjoy no exemption from complete preemption under Section 502(a). In *both cases*, the Court unanimously held that ERISA completely preempted *state-law tort claims*. *Pilot Life*, 481 U.S. at 48-49 (discussing the Mississippi tort of bad faith), *see Metropolitan Life*, 481 U.S. at 61-62. Indeed, here as in *Pilot Life*, tort actions seek to import state-law standards of reasonableness and adequacy into a benefits adjudication. *See, e.g., Pilot Life*, 481 U.S. at 49-50 (citing Mississippi cases that demonstrate that the bad faith tort applies when the failure to perform on a contract is done without a reasonable basis); App., *infra*, at 17a (noting Davila's reliance on the Texas standard of "'ordinary care'"). It was precisely this importation of individual States' common law of reasonableness into the employee benefits context, where uniformity is paramount, that *Pilot Life* forbade. *Pilot Life*, 481 U.S. at 56 ("The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop * * * would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws."). The rule announced in the decision below—categorically immunizing tort claims from complete preemption—cannot coexist with the holding of either *Pilot Life* or *Metropolitan Life*.

Finally, these decisions confirm the inappropriateness of the Fifth Circuit's focus on the *form of relief* available under a state cause of action as a basis for holding the state claim not "duplicative" and therefore not preempted. In particular, *Pilot Life* expressly rejected the notion that Congress could have left ERISA participants and beneficiaries "free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. Indeed, drawing on the analogous context of the Labor-Management Relations Act, which also gives rise to complete preemption, *Pilot Life* noted that Congress used the LMRA as a model for ERISA knowing full well "that the powerful pre-emptive force of § 301 of the LMRA displaced all state actions for violation of contracts between an employer and a labor organization, *even when the state action purported to authorize a remedy unavailable under the federal provision*." *Id.* at 55 (emphasis added). By focusing on the availability of *damages* under the THCLA, the Fifth Circuit directly undercut this core holding.

2. This Court has never departed from—and indeed has repeatedly reaffirmed—the analysis it adopted in *Pilot Life* and *Metropolitan Life*. For example, three years after those decisions, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the plaintiff alleged that he had been terminated to prevent his pension benefits from vesting. He filed suit in Texas state court, alleging that his employer had tortiously violated the state-law duty of good faith and fair dealing, as well as claims for wrongful discharge and breach of contract. *McClendon v. Ingersoll-Rand Co.*, 779 S.W.2d 69, 69-70 & n.1 (Tex. 1989). The Texas Supreme Court allowed his action to go forward, noting that he was seeking compensatory and punitive damages rather than the recovery of pension benefits that ERISA would have permitted him. *Id.* at 71 n.3.

As in *Pilot Life* and *Metropolitan Life*, this Court unanimously concluded that the state-law claims were completely preempted by Section 502(a)'s exclusivity. *Ingersoll-Rand*,

498 U.S. at 144-45. Because the plaintiff's right to benefits was guaranteed by ERISA, this Court concluded that his exclusive avenue of redress was Section 502. *Id.* at 145. That the plaintiff had claimed to be seeking relief in tort and contract damages, rather than in the equitable recovery of pension benefits that ERISA affords, did not matter, the Court held; the conflict was with the exclusivity of the ERISA causes of action. *Id.*

Ingersoll-Rand compellingly reinforces the conclusion that the decision below cannot be reconciled with this Court's precedents. For example, the court of appeals reasoned that "[b]ecause the THCLA does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*." App., *infra*, at 20a. Virtually identical reasoning had been adopted by the Texas Supreme Court in *Ingersoll-Rand*. That court had reasoned that complete preemption did not apply because the plaintiff "was '*not* seeking lost * * * *benefits* but [was] instead seeking lost future wages, mental anguish and punitive damages * * *.'" *Ingersoll-Rand*, 498 U.S. at 136 (quoting *McClendon*, 779 S.W.2d at 71 n.3) (emphases and second alteration in original). This Court squarely disagreed, holding that "there is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek * * * 'benefits.'" 498 U.S. at 145. As this Court put it, "it is no answer to a pre-emption argument that a particular plaintiff is not seeking recovery of * * * benefits." *Id.*

The Fifth Circuit gave only the most cursory attention to *Ingersoll-Rand*: The court merely stated in passing that this Court's most recent decision under ERISA § 502(a)—*Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)—had "explained" that *Ingersoll-Rand* simply applied a "duplication" test. *See* App., *infra*, at 19a-20a. But even the language that the Fifth Circuit quoted from *Rush Prudential* to support that assertion made clear that any state law that *adds* remedies such as money damages, or any law that provides a

state (rather than federal forum) for benefit disputes, is preempted (*id.* at 19a-20a)—precisely the rule that the Fifth Circuit disregarded in this case.[5]

Directly contrary to the Fifth Circuit's reading, this Court's decision in *Rush Prudential* expressly adhered to and reaffirmed the teaching of *Pilot Life*. *Rush Prudential* considered a claim by a plaintiff who had sought coverage from her HMO for an "unconventional treatment." 536 U.S. at 360. When the HMO denied coverage and instead proposed to cover a more standard treatment, the plaintiff sued in state court to demand an independent medical review, as guaranteed by a state statute, and payment for the unconventional procedure. The Seventh Circuit held that the case was properly removed to federal court, because this Court's precedents required that the state suit be recharacterized as an action under ERISA § 502(a). *See Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 967 (7th Cir. 2000), *aff'd*, 536 U.S. 355 (2002). The Seventh Circuit ruled, however, that the state statute requiring an independent medical review was not preempted, and could be enforced *in federal court only* in an action under ERISA § 502(a).

[5] In the language from *Rush Prudential* on which the Fifth Circuit relied, this Court explained that the state law at issue in *Ingersoll-Rand* had "'duplicated the elements of a claim available under ERISA'" because "'it converted the remedy from an equitable one under § [502(a)(3)] (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal).'" App., *infra*, at 19a-20a (quoting *Rush Prudential*, 536 U.S. at 379). That passage makes clear that this Court was not using "duplication" in the narrow sense adopted by the Fifth Circuit—*i.e.*, permitting preemption only of state claims that replicate the contractual-type remedies provided by ERISA. Not surprisingly, the Court in *Rush Prudential* took particular pains to reaffirm *Ingersoll-Rand*, which most directly illustrates the conflict between the decision below and this Court's cases. *Rush Prudential*, 536 U.S. at 379, 380 (observing that the Texas law invalidated in *Ingersoll-Rand* had "patently violate[d]" the uniformity mandated by Section 502(a) and "exemplified" the "sort of additional claim or remedy" that ERISA completely preempts).

In affirming that conclusion, this Court agreed that "medical necessity" determinations of the type at issue here are ERISA benefit determinations. See *Rush Prudential*, 536 U.S. at 361, 365 (stating that the Illinois law allowing independent review of "medical necessity" determinations added "an extra layer of review for certain benefit denials"). In fact, all nine Members of the Court agreed that if the independent review statute had created an additional *claim* or an additional *remedy*, it would have been preempted under *Pilot Life* and its progeny. *See id.* at 379-80 ("[T]he state statute does not enlarge the claim for benefits beyond the benefits available in any action brought under § [502(a)]. And * * * the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § [502(a)]. This case therefore does not involve the sort of additional claim or remedy exemplified in *Pilot Life*, [*Metropolitan Life*], and *Ingersoll-Rand* * * *." (footnote omitted)); *id.* at 388 (Thomas, J., dissenting) (citing *Pilot Life* for the proposition that, "as the Court concedes," a state-law claim is preempted "if it supplements the remedies provided by ERISA"). *Rush Prudential* turned not on any disagreement over the vitality of *Pilot Life*'s prohibition on benefits adjudications that supplement Section 502(a), but on the majority's determination that the independent review provision was sufficiently different from arbitration or adjudication that it *was not* an alternative means of determining entitlement to benefits that would be forbidden under *Pilot Life*. *See id.* at 381-82. And notably, *no* Member of this Court questioned the Seventh Circuit's holding that the case was properly removed from the state courts.

3. Most recently, in *Beneficial National Bank v. Anderson*, 123 S. Ct. 2058 (2003), the Court once again endorsed the principle of *Metropolitan Life*. Explaining that the principle of complete preemption applies *whenever* Congress creates an exclusively federal right of action, the Court held that claims for usury necessarily arise under the National Bank Act and are removable to federal court. *Id.* at 2063-64. Although the plaintiff pleaded state law usury claims that apparently could not survive on their merits once recharacterized as federal (*see id.* at 2063), the Court nonetheless upheld removal. And the Court took pains to reaffirm its adherence to the rule announced in *Metropolitan Life*—and on this point, it was once again unanimous. *See id.* at 2062-63, 2064 (opinion for the Court); *id.* at 2067 n.1 (Scalia, J., dissenting).

Beneficial confirms that the panel below erred in focusing so narrowly on whether a state cause of action "duplicates," in some ill-defined but narrow sense, a federal one. Confining the inquiry to duplication would rob the "complete preemption" doctrine of all of its force. Completely preemptive federal statutes "supersede both the substantive and the remedial provisions" of state law. *Beneficial*, 123 S. Ct. at 2064. The essence of the complete preemption doctrine is that states may not create a path around the exclusively federal *remedial* scheme simply by inventing a cause of action whose elements bear some substantive difference from the federal law—but which still regulates the same subject matter. Yet the approach taken by the Fifth Circuit in this case would allow States to create a path around the exclusively federal remedial scheme without even creating a substantive difference at all, but simply by *allowing a different remedy*. *See* App., *infra*, at 10a (holding that Section 502(a)(3) did not preempt the THCLA claims because it allows only equitable relief, "not the damages claims Calad and Davila bring"). *Beneficial* confirms that the key question is not how the state-law claim is articulated, but whether the conduct it challenges

is the subject of such an exclusively federal remedial scheme. Here, the challenged conduct—coverage pre-approval—clearly is a benefits-administration decision, subject to the exclusively federal remedial scheme of Section 502(a).

From *Pilot Life* through *Rush Prudential* and now *Beneficial*, the Court's decisions have consistently adhered to a set of three principles. First, ERISA's remedial provisions are exclusive; because Congress carefully weighed which rights of action to include and which to omit, any right of action *not* included must be deemed to have been *excluded*. *Pilot Life*, 481 U.S. at 54; *see Rush Prudential*, 536 U.S. at 378-79; *Ingersoll-Rand*, 498 U.S. at 144-45. Second, the policy choice embodied in Section 502(a)'s balanced set of remedies is binding on the States, which may not add to, subtract from, vary, or replicate any of these rights of action. Attempts to add a supplementary right of action are preempted. *Rush Prudential*, 536 U.S. at 379-80; *Pilot Life*, 481 U.S. at 56. Third, the complete preemption of a state cause of action turns not on the manner in which it is pleaded (tort, contract, or otherwise) or on the relief it seeks (at law or in equity), but on whether it interferes with the administration of benefits under an ERISA plan. *Pilot Life*, 481 U.S. at 51-52. Because the Fifth Circuit's decision runs directly contrary to each and every one of these principles, review by this Court is warranted to correct the Fifth Circuit's plain departure from this Court's precedents.

II. Other Federal Courts Have Continued To Apply *Pilot Life*'s Holding That Alternative Enforcement Mechanisms Are Completely Preempted

As the majority of courts of appeals have recognized, *Pilot Life* and *Metropolitan Life* foreclosed ERISA plan participants from invoking or inventing alternative state-law claims for denial of benefits by mere artful pleading. Further, those courts of appeals have adhered to those precedents without—as did the court below—reading into this Court's

more recent cases an intent to retreat from the complete preemption doctrine.

1. In *Marks v. Watters*, 322 F.3d 316, 327 (4th Cir. 2003), for example, the Fourth Circuit reaffirmed that plaintiffs may not circumvent Section 502(a)'s exclusivity by bringing state-law claims relating to benefits administration—however cleverly those claims might be characterized. *Marks* arose when an ERISA plan beneficiary checked out of the mental hospital where his insurer had approved psychiatric care, and then killed his family and himself. *Id.* at 320-21. The decedents' estates sued the insurer, alleging medical malpractice, negligence, and other state-law claims. *Id.* at 318. They contended that the plan administrator had committed negligence by causing the hospital to discharge the patient prematurely, or by referring him (allegedly based on cost) to a less desirable facility. *Id.* at 327. They argued, as did the Fifth Circuit in this case, that ERISA does not preempt state-law claims based on insurers' mixed decisions of plan administration and patient treatment—a category drawn from this Court's opinion in *Pegram*. *See id.* at 318, 322.

The Fourth Circuit rejected the contention that mixed eligibility and treatment decisions are categorically exempt from Section 502(a)(1)'s exclusive remedial provision. Preemption is determined by the substance of the claim, the court wrote, and the plaintiffs' claims were at their core claims about benefits administration. The court elaborated:

> Claims challenging the administration of an employee welfare benefit plan fall squarely within the scope of § 502(a) of ERISA. Such claims include allegations that a plan benefit was denied based on noncompliance with the terms of a plan or allegations that an ERISA fiduciary breached a duty to a plaintiff by improperly denying a benefit based solely on financial motivations. The core allegation underlying a § 502(a) claim is that a plan participant

> or beneficiary was denied a benefit to which the participant or beneficiary was entitled under an ERISA plan or that *the manner of administering the benefits caused the participants or beneficiaries some injury*. These are precisely the types of claims that plaintiffs are making * * * .

Marks, 322 F.3d at 326 (emphasis added). Thus, the *Marks* plaintiffs, like Davila, sought to engraft a state law duty of care—enforceable through money damages—onto the administration of an ERISA plan. Yet confronted with comparable facts, the Fourth Circuit reached precisely the opposite result.

Similarly, in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), the Third Circuit made clear that Section 502(a) provides the sole means of challenging "core managed care practices," even when, as here, those practices consist of allegedly "mixed" decisions that rely on medical judgments as predicates for a coverage decision. *Id.* at 274-75. The plaintiff in *Pryzbowski* sought to challenge her insurer's delay in pre-approving a surgical procedure, a delay that resulted from the HMO's preference for the use of in-network specialists. *Id.* at 273. She asserted claims sounding in tort, including negligence and bad faith. *Id.* at 270. The Third Circuit noted that the plaintiff's claim fell somewhere in between a claim challenging only a benefits determination, such as a refusal to approve services not covered by the plan, and one challenging the quality of medical care by a treating physician. *Id.* at 273. The court noted, however, that the insurer (like Aetna) did not itself provide the medical services, and that notwithstanding the medical component to its coverage decisions, those decisions necessarily fell "squarely within administrative function." *Id.* at 274. Thus, although the damages the plaintiff sought were not available under Section 502, that provision represented her exclusive means

of challenging a decision relating to benefit administration. *See id.* at 273-75.

In *Hotz v. Blue Cross & Blue Shield of Massachusetts, Inc.*, 292 F.3d 57 (1st Cir. 2002), the First Circuit also recently reaffirmed that an attack on a pre-approval decision is completely preempted, irrespective of how the claim is characterized. The plaintiff in *Hotz* brought suit under a state unfair-claim-settlement statute to challenge her insurer's allegedly unreasonable delay in the approval of a recommended procedure—a delay that allegedly caused the plaintiff's cancer to worsen. *Id.* at 58. The court reexamined and adhered to its prior precedent, which had held that state-law tort claims challenging a utilization review decision are completely preempted by ERISA. *Id.* at 60 (citing *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999)). The critical inquiry, the *Hotz* court held, is whether the claim "challenged 'the process used to assess a participant's claim for a benefit payment under the plan.'" *Id.* (quoting *Danca*, 185 F.3d at 6). Such claims—including claims sounding in tort for money damages—fall "within the ambit" of ERISA's exclusive remedial provision and are completely preempted. *Id.*; *see id.* at 58 n.1 (describing the cause of action for damages and attorney's fees). Despite any alleged "shift of emphasis by the Supreme Court," the First Circuit held, *id.* at 61 (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999)), a state action for damages and attorney's fees was precisely within the scope of the *Pilot Life* rule and thus completely preempted. *Id.*

Notably, *Hotz* significantly postdated this Court's decision in *Pegram*, on which the Fifth Circuit based its distinction of this Court's complete preemption cases. Yet the *Hotz* court was not distracted, as was the court below, by *Pegram*'s elaboration—outside the preemption context—of the distinction among treatment decisions, eligibility decisions, and mixed decisions by treating physicians. In the case on

which the *Hotz* court principally relied, the First Circuit had previously anticipated the development of that taxonomy and dismissed it as irrelevant to the scope of complete preemption under ERISA. Considering state-law tort claims brought against an insurer for routing a mental patient to a less expensive and allegedly inferior hospital, the First Circuit "recognize[d] that the allegedly negligent decisionmaking and consultation at issue [might] be characterized as medical in nature," but held that "this fact alone d[id] not remove the state causes of actions [*sic*] from the scope of § 502(a)." *Danca*, 185 F.3d at 5-6. Rather, the conduct at issue, which the court termed "quasi-medical," fell squarely within the scope of the *Pilot Life* preemption doctrine. *Id.* at 6. Thus, unlike the court below, the *Danca* court recognized that a plaintiff cannot circumvent the limitations of Section 502(a) merely by characterizing a claim for benefits as a "mixed decision."

Like *Pryzbowski*—which the First Circuit cited with approval, *see Hotz*, 292 F.3d at 60—*Hotz* cannot be reconciled with the decision below. The *Hotz* court correctly deemed the central inquiry in the preemption analysis to be whether the claim "challenged 'the process used to assess a participant's claim for a benefit payment under the plan.'" *Id.* (quoting *Danca*, 185 F.3d at 6). Davila's claim falls squarely within that category, as he alleges injury arising out of the use of the "step plan" to evaluate and pre-approve claims for prescription drug coverage. Yet the Fifth Circuit's incorrect analysis led it to reach a holding inconsistent with those of its sister circuits.

On similar facts, the Eighth Circuit has also consistently held that decisions about the levels of care that will be authorized under an ERISA plan are benefits administration questions, even though they may contain an element of medical judgment. Indeed, the Eighth Circuit "has expressly declined invitations to either expand or contract the *Pilot Life*

doctrine that ERISA's civil enforcement remedies preempt conflicting or competing state law judicial remedies," *Fink v. Dakotacare*, 324 F.3d 685, 689 (8th Cir. 2003), and has consistently held that all attempts to plead medical malpractice, breach of fiduciary duty, or similar tort claims to challenge "mixed" coverage and treatment decisions are completely preempted by ERISA.

The Eighth Circuit's decision in *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam), is emblematic. Just as Davila alleged negligence stemming from the refusal to prescribe a more suitable, less toxic anti-arthritis drug at the outset of treatment, so Thompson alleged malpractice from the refusal to authorize a more suitable, more aggressive course of treatment. The Eighth Circuit rejected the plaintiff's contention that ERISA leaves room for state-law tort regulation, and it noted that the "patient and her treating physicians retained the ultimate decision-making authority regarding her medical care. If she disagreed with Gencare's pre-certification decisions, ERISA afforded her a timely equitable remedy to review Gencare's interpretation of the plan, a remedy she did not pursue." *Id.* at 1074. And that remedy remains exclusive under the *Pilot Life* line of cases. *Id.* at 1073. Numerous other cases in the Eighth Circuit stand for the same proposition. *See, e.g.*, *Howard v. Coventry Health Care, of Iowa, Inc.*, 293 F.3d 442, 446 (8th Cir. 2002) (per curiam); *Hull v. Fallon*, 188 F.3d 939, 942-43 (8th Cir. 1999) (holding completely preempted a medical malpractice claim against a health plan administrator who allegedly made an improper determination that a thallium stress test was not "medically necessary" under the plan's definition); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 438-40 (8th Cir. 1997) (holding completely preempted a breach of fiduciary duty claim against a plan whose administrator refused to precertify experimental cancer coverage).

Rounding out the circuits adhering to the majority view, the Tenth Circuit likewise has rejected the notion that subsequent authority has undermined *Pilot Life* or its progeny so as to permit plan beneficiaries to sue in tort. In a recent decision, that court adhered to its prior precedent holding that a state tort action for bad faith was an impermissible attempt to obtain remedies precluded by Section 502(a), and therefore ruled that such an action was completely preempted. *Conover v. Aetna U.S. Healthcare, Inc.*, 320 F.3d 1076, 1079-80 (10th Cir. 2003) (citing *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 466 (10th Cir. 1997)); *see also Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1272-75 (10th Cir. 1996) (holding completely preempted a claim against a managed care company for allegedly negligent "refus[al] to authorize" medical treatment). Indeed, quite unlike the court below, the Tenth Circuit observed that this Court's *Rush Prudential* opinion had "*reaffirmed* this portion of the *Pilot Life* decision." *Conover*, 320 F.3d at 1078 n.2 (emphasis added).[6]

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[6] While several courts of appeals—unlike the decision below—have expressly reaffirmed the vitality of *Pilot Life* since this Court's decision in *Pegram*, the decisions applying *Pilot Life* in analogous circumstances before *Pegram* are legion. In *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485 (7th Cir. 1996), for example, the plaintiff's heath insurer approved only a knee replacement, without the associated physical therapy. Jass underwent the therapy but did not undergo rehabilitation; she promptly sued in state court asserting that the insurer's negligence caused the resulting scarring. Although there was certainly a medical aspect to the decision not to approve the therapy, the claim against the HMO was "in effect a claim for denial of benefits." *Id.* at 1489. The court accordingly held that the claim was completely preempted. *Accord Parrino v. FHP, Inc.*, 146 F.3d 699, 702-03 (9th Cir. 1998); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 940-41 (6th Cir. 1995).

2. Although the weight of circuit authority continues to hold that Section 502(a) completely preempts participants' and beneficiaries' attempts to challenge benefits determinations by bringing tort actions, the instant case is not the only decision that diverges from the majority rule on this point. In an opinion rendered after the decision below, the Second Circuit broadened the circuit split that this case presents by substantially agreeing with the Fifth Circuit. In *Cicio v. Doe*, 321 F.3d 83 (2d Cir. 2003), as in this case, the Second Circuit considered an HMO's decision to approve a treatment less elaborate than the course sought by the patient and his treating physician. *See id.* at 88. The plaintiff and his physician sought a double stem-cell transplant to treat the patient's multiple myeloma; the patient's HMO refused to pay for the double transplant, as an "experimental/investigational" treatment that was not covered by the plaintiff's plan. *Id.* (The HMO offered a less expensive alternative.) Upholding state-law claims for medical malpractice, *id.* at 90, a divided panel of the Second Circuit held that although the HMO's conduct involved an aspect of benefits administration, the simultaneous presence of a medical component subjected the HMO's decision to regulation under state law. *See id.* at 103.

Expressly disagreeing with the Third Circuit, *see id.* (rejecting *Pryzbowski*, 245 F.3d at 279), and following the same course as the court below, *Cicio* relied on the "mixed eligibility and treatment decision" formulation from *Pegram* and held that state claims challenging such decisions are not preempted by ERISA. *Id.* at 104. The court also stated that "nothing in ERISA suggests that Congress intended any displacement of 'the quintessentially state-law standards of reasonable medical care.'" *Id.* at 103 (quoting *Rush Prudential*, 536 U.S. at 387). This assertion is precisely contrary to *Ingersoll-Rand* (a decision that, as noted, the *Rush Prudential* Court took pains to approve), which teaches that the comprehensiveness of ERISA's *remedial* provision points to just such a displacement by Section 502(a). *Ingersoll-Rand*, 498

U.S. at 144 ("It is clear to us that the exclusive remedy provided by § 502(a) is precisely the kind of special feature that warrant[s] pre-emption in this case." (alteration in original; internal quotation marks omitted)). Thus, the Second Circuit has exacerbated the circuit split over the current vitality of *Pilot Life* and its progeny.

Dissenting in *Cicio*, Judge Calabresi pointed out a number of analytical errors that recur both in the majority opinion in *Cicio* and in the Fifth Circuit decision in this case. For Judge Calabresi, it was not even necessary to decide whether *Rush Prudential* had somehow narrowed the scope of *Pilot Life*. *See Cicio*, 321 F.3d at 108 & n.2 (Calabresi, J., dissenting in part). Because the insurer's challenged decision was plainly one of coverage, even if it could be viewed as incorporating aspects of "medical judgment," it was plainly preempted. *Id.* at 108-09. Noting that "*Pegram*, of course, was not a preemption decision," Judge Calabresi also pointed out that "coverage decisions * * * can be made for any number of reasons, medical and non-medical." *Id.* at 109 & n.4. "Even accepting [a] more limited * * * scope of preemption," Judge Calabresi explained that the analysis was unchanged:

> The answer lies in whether the suit, in its essence, is to obtain relief for the violation of rights under the terms of the ERISA plan, in which case the state action is preempted, or whether it is a suit for malpractice *against a doctor* (or the doctor's employer) as to which the existence of ERISA coverage is only incidental. To put it another way, if ERISA were not there, would this suit essentially be against an insurance provider for negligently failing to give the coverage contracted for, or would the suit be against a medical care provider for negligent failure to treat? Because I think the current suit is clearly of the first sort, I regretfully conclude that it is barred.

Id. at 108 (emphasis added). Judge Calabresi correctly focused on whether "the suit, in its essence," was one based on the violation of rights under an ERISA plan, not—as did the court below—on whether the formal elements of the state-law claims are *identical* to the elements of an ERISA claim.

Although Judge Calabresi was in dissent, his analysis is consistent with that employed by a majority of the courts of appeals. The weight of authority holds that state tort claims may be preempted by ERISA, and that this Court's recent decisions countenance no retreat from this core holding of *Pilot Life* and its progeny. The decision below and the majority opinion in *Cicio* erroneously diverge from that consensus. Because the Fifth Circuit (in this case) and the Second Circuit (in *Cicio*) both have declined to reconsider the question *en banc*,[7] only this Court's intervention can restore uniformity to this important area of federal law.

III. The Circuit Split On This Issue Is Firmly Entrenched, And This Court's Review Is Warranted To Resolve A Question Of Considerable National Significance

The issue presented by this case is a significant and recurring one. Millions of Americans receive medical insurance through employer-provided health plans governed by ERISA, and many of those health plans rely on HMOs as a means of providing cost-effective care. Indeed, as this Court recognized in *Pegram*, the very reason for HMOs' existence is to maximize the cost-efficiency of the health care services provided to their members. Cost-efficiency necessarily involves the institution of cost-management policies like the one at issue in this case, which holds certain more expensive prescription medications in reserve and gives more readily

[7] *See* App., *infra*, at 36a; Order, *Cicio v. Doe*, No. 01-9248 (2d Cir. Apr. 21, 2003).

accessible medications a chance to work. *E.g.*, *Pryzbowski*, 245 F.3d at 274-75. Disputes over benefits are therefore frequent, and Congress, after extensive study and with considerable care, constructed an elaborate framework by which to ensure uniform treatment of these disputes by ERISA plans.

The decision below clearly flouts that framework, to say nothing of numerous decisions of this Court. Indeed, even if the Fifth Circuit were correct in perceiving a shift in this Court's preemption jurisprudence (and it is not), its failure to abide by *Pilot Life*, *Metropolitan Life*, and *Ingersoll-Rand* would itself be grounds for this Court's intervention. This Court has previously rebuked the Fifth Circuit for failure to accord due weight to the governing precedents of this Court, stating unambiguously:

> If a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the Court of Appeals should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.

Rodriguez de Quijas v. Shearson/Am. Express Inc., 490 U.S. 477, 484 (1989); *accord, e.g.*, *id.* at 486 (Stevens, J., dissenting); *State Oil Co. v. Khan*, 522 U.S. 3, 20 (1997); *Agostini v. Felton*, 521 U.S. 203, 237 (1997). In the circumstances of this case, the Fifth Circuit's plain refusal to follow controlling authority could appropriately be remedied by summary reversal.

In any event, the issue presented by this case is ripe for this Court's intervention, whether plenary or summary. The divide among the circuits over the proper interpretation of a far-reaching federal statute—and this Court's construction of it—has sufficiently calcified that this Court's resolution of the issue is necessary. The paramount objective of ERISA is a uniform federal body of benefits law. The persistence of the blinkered approach to Section 502(a) preemption that this

case exemplifies frustrates that objective and warrants this Court's intervention.

CONCLUSION

The petition for a writ of certiorari should be granted. The Court may wish to consider summary reversal.

Respectfully submitted.

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June 20, 2003

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

Nos. 01-10831, 01-10891 and 01-10905.

[Filed Sept. 17, 2002]

ROBERT ROARK; ROBERT ROARK, ON BEHALF OF THE ESTATE OF GWEN ROARK,

Plaintiffs-Appellants,

v.

HUMANA, INC.; HUMANA HEALTH PLAN OF TEXAS, INC., DOING BUSINESS AS HUMANA HEALTH PLAN OF TEXAS (DALLAS), DOING BUSINESS AS HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO), DOING BUSINESS AS HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI); HUMANA HMO TEXAS, INC.,

Defendants-Appellees.

RUBY R. CALAD,

Plaintiff-Appellant-
Cross-Appellee,

WALTER PATRICK THORN,

Plaintiff-Cross-Appellee,

v.

CIGNA HEALTHCARE OF TEXAS, INCORPORATED, DOING BUSINESS AS HEALTHSOURCE, DOING BUSINESS AS CIGNA CORPORATION,

Defendant-Appellee,

AETNA U.S. HEALTHCARE; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,

Defendants-Appellees-
Cross-Appellants.

JUAN DAVILA,

Plaintiff-Appellant,

v.

AETNA U.S. HEALTHCARE, INC.; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,

Defendants-Appellees.

Before SMITH, BENAVIDES, and PARKER, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

This suit consolidates multiple district court actions and appeals for consideration of common issues. Ruby Calad, Walter Thorn, Juan Davila, and Gwen Roark sued their respective health maintenance organizations ("HMO's") for negligence under Texas state law: They alleged that although their doctors recommended treatment, the HMO's negligently refused to cover it. The HMO's removed to federal court, arguing that because each plaintiff received HMO coverage through his employer's ERISA plan, the claims arose under ERISA. The plaintiffs moved to remand.

The respective district courts denied Calad, Davila, and Roark's remand motions and dismissed their claims under FED. R. CIV. P. 12(b)(6), citing ERISA preemption. The district court granted Thorn's remand motion. Roark, Calad, and Davila appeal the refusal to remand and, in the alternative, the dismissal. Thorn's HMO appeals the remand. We affirm the judgments in Roark's and Thorn's cases and reverse with respect to Calad and Davila.

I.

A. Ruby Calad

Through her husband's employer, Calad became a member of CIGNA HealthCare of Texas, Inc. ("CIGNA"), a Texas HMO. Calad underwent a hysterectomy with rectal, bladder, and vaginal repair. The surgery was performed by a CIGNA physician. Although that doctor recommended a longer stay, CIGNA's hospital discharge nurse decided that the standard, one day hospital stay would be sufficient. Calad suffered complications that returned her to the emergency room a few days later; she attributes these complications to her early release.

Calad sued in state court under the Texas Health Care Liability Act ("THCLA"),[1] alleging CIGNA had failed to use ordinary care in making its medical necessity decisions, CIGNA's system made substandard care more likely, and CIGNA acted negligently when it made its medical necessity decisions. CIGNA removed to federal court based on ERISA preemption. Calad moved to remand, but the court denied the motion. The court noted "that Calad has repeatedly made clear that, should the Court deny her motion to remand, she will not amend her pleading to bring an ERISA claim and therefore requests that her claims be dismissed." Accordingly, the court dismissed under rule 12(b)(6).

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[1] TEX. CIV. PRAC. & REM. CODE §§ 88.001-88.003.

B. Walter Thorn

Thorn received Aetna U.S. Healthcare insurance through his employer. He injured his hand in a car accident, and doctors amputated his ring finger. The doctors said he needed surgery in two to three days, or he would lose his hand. An Aetna-designated specialist scheduled the surgery for the next day.

A few hours before the scheduled surgery, Aetna refused to authorize its surgeon to operate. While Aetna reviewed the case, it sent a physical therapist to help exercise Thorn's hand, so it would not deteriorate while Thorn waited for surgery. Aetna eventually approved the surgery, but Thorn contends that Aetna's delay caused scarring that has diminished his manual mobility.

Thorn sued jointly with Calad. Initially, Calad and Thorn alleged that CIGNA and Aetna were jointly and severally liable. They later withdrew this allegation, explaining it was a pleading error. Thus, Calad's claims run only against CIGNA, and Thorn's runs only against Aetna. CIGNA removed to federal court (with Aetna's consent), citing ERISA preemption. Thorn moved to remand, arguing that ERISA excludes government plans such as his from preemption. The district court remanded Thorn's claim.

C. Juan Davila

Davila is a post-polio patient who suffers from diabetes and arthritis. He received Aetna HMO coverage through his employer's health plan. His primary care physician prescribed Vioxx for Davila's arthritis pain. Studies have shown that Vioxx has a lower rate of gastrointestinal toxicity (e.g., bleeding, ulceration, perforation of the stomach) than do the other drugs on Aetna's formulary. Before filling the prescription, Aetna required Davila to enter its "step program": Davila first would have to try two different medications; only if he suffered a detrimental reaction to

the medications or failed to improve would Aetna evaluate him for Vioxx use.

As part of the step program, Davila first was given naprosyn (a cheaper pain reliever). After three weeks, he was rushed to the emergency room. The doctors reported he suffered from bleeding ulcers, which caused a near heart attack and internal bleeding. The doctors gave Davila seven units of blood and kept him in critical care for five days. Now he cannot take any pain medication that is absorbed through the stomach.

Davila sued in state court under the THCLA, alleging Aetna had failed to use ordinary care in making medical necessity decisions, Aetna's systems made substandard care more likely, and Aetna acted negligently in making its medical necessity decisions. Aetna removed to federal court, citing ERISA preemption.

Davila moved to remand. The court concluded that some of Davila's claims were completely preempted under ERISA § 502(a) and thus denied remand. The court noted that normally it would dismiss Davila's state law claims and grant him leave to file an amended complaint under ERISA. But, because Davila had informed the court he would not pursue an ERISA claim, it instead dismissed with prejudice under rule 12(b)(6).

D. Gwen Roark

In 1990, Roark was bitten by what was believed to be a brown recluse spider. The bite damaged the skin, muscle, and bone of her left leg, requiring antibiotics, three skin graft operations, and two surgeries to create "free flaps" over her wound. In 1997, Roark began using a vacuum-assisted closure device ("VAC") to circulate blood to the skin's surface and quicken healing. Each day, a nurse came to Roark's home and spent two hours scraping the wound with a scalpel;

Roark wore the VAC for the other twenty-two hours of the day.

Later that year, Humana Health Plan of Texas ("Humana") became the Roarks' HMO. Roark's primary care physician recommended she continue using the VAC and authorized treatment. In 1998, Humana delayed the VAC treatments and home nursing several times; upon each delay, Roark filed an immediate appeal or grievance. The primary care physician told Humana that without the VAC and home nursing case, Roark could lose her leg. Humana eventually approved the VAC for ninety days. Humana periodically delayed VAC and home nursing treatment until December 1998, when it cancelled home nursing altogether. Humana agreed to pay only for visits to a local hospital's wound center.

In February 1999, Roark developed a serious infection that required the doctors to amputate her leg that March. While Roark was convalescing, Humana again denied her VAC treatment that may have helped heal the amputation wound. In January 2000, the doctors performed an additional amputation treatment on her leg.

Roark and her husband Robert sued in state court under the THCLA, the Texas Deceptive Trade Practices Act ("DTPA"),[2] the Texas Insurance Code,[3] and common law breach of good faith, fair dealing, and contract. Humana removed to federal court, citing ERISA preemption. The Roarks moved to remand. The court found that the Roarks' DTPA and insurance claims were completely preempted under ERISA § 502(a) and thus denied the motion.

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2 TEX. BUS. & COM. CODE § 17.46(a), (b)(5), (b)(12).

3 TEX. INS. CODE art. 21.21 §§ 4(1), (2), (11)(a), (11)(c).

The Roarks then amended their complaint to allege only violations of the THCLA—that Humana had failed to use ordinary care when it made its medical necessity decisions, Humana's system made substandard care more likely, and Humana was negligent in making its medical necessity decisions—and filed a second remand motion. The court held that ERISA § 502(a) preempts the THCLA claim as well, denied the Roarks' motion to remand, and dismissed under rule 12(b)(6).

The court gave the Roarks thirty days to replead under ERISA § 502(a), failing which their case would be dismissed with prejudice under rule 12(b)(6). The Roarks declined and filed this appeal challenging the second remand order. The district court never entered the final order dismissing the case with prejudice under rule 12(b)(6), but it did list the case closed for statistical purposes. The Roarks' notice of appeal also states that they will not replead under ERISA.

II.

A. Calad's and Davila's remand motions

With exceptions not relevant here, "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a). If, before final judgment, it appears the case was not properly removed because it was not within the federal courts' original jurisdiction, the district court must remand. 28 U.S.C. § 1447(c).

The "well-pleaded complaint rule" limits federal courts' original jurisdiction to those cases in which the plaintiffs complaint states a cause of action arising under federal law; a federal defense will not do. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 9-10 (1983) (citing *Louisville & Nashville R.R. v. Mottley*, 211 U.S. 149 (1908)).

"[S]ince 1887 it has been settled law that a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiffs complaint, and even if both parties admit that the defense is the only question truly at issue in the case." *Franchise Tax Bd.*, 463 U.S. at 13-14.

Calad and Davila advance only state law causes of action; a straightforward application of the well-pleaded complaint rule would deprive the federal courts of original and removal jurisdiction over their claims. But, we recognize an exception to the well-pleaded complaint rule for those few statutes whose "preemptive force . . . is so powerful as to displace entirely any state causes of action." *Id.* at 23. Where "a federal cause of action completely preempts a state cause of action, any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Id.* at 24. Such actions are excepted from the well-pleaded complaint rule and confer original and removal jurisdiction. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66, (1987); *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 336 (5th Cir. 1999). The Supreme Court first recognized this exception for § 301 of the Labor-Management Relations Act ("LMRA")[4] and has extended the rule to some, but not all, cases under ERISA.[5]

ERISA provides two types of preemption: complete preemption under § 502(a) and conflict preemption under § 514. *Giles*, 172 F.3d at 336; *McClelland v. Gronwaldt*, 155 F.3d 507, 515-17 (5th Cir. 1998). "Section 502, by providing

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[4] *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968); *see also Franchise Tax Bd.*, 463 U.S. at 23.

[5] *Metropolitan Life*, 481 U.S. at 64-65.

a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief." *Id.* at 337.

Section 502(a) complete preemption is a slight misnomer, for it does not involve traditional preemption analysis. *McClelland*, 155 F.3d at 516 ("Complete preemption is less a principle of substantive preemption than it is a rule of federal jurisdiction."). We do not ask whether the state law conflicts with or frustrates a congressional purpose, but whether the state law duplicates or "falls within the scope of" an ERISA § 502(a) remedy. *Taylor*, 481 U.S. at 64; *McClelland*, 155 F.3d at 518. If Calad and Davila could have brought their claims under ERISA § 502(a), the claims would be completely preempted, and the district court would have been correct to exercise jurisdiction.

Section 514, in contrast, provides for ordinary conflict preemption.[6] State law claims that fall outside § 502(a), even though preempted by § 514, follow the well-pleaded complaint rule and do not confer original or removal jurisdiction. *Franchise Tax Bd.*, 463 U.S. at 23-27; *Giles*, 172 F.3d at 337.

We review the district court's preemption analysis, which formed the basis for its subject matter jurisdiction, *de novo*. *McClelland v. Gronwaldt*, 155 F.3d 507, 511 (5th Cir. 1998). Because we conclude that § 502(a) does not displace Calad's or Davila's claims, the district court should have remanded.

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[6] ERISA § 514(a) preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a).

The enforcement provisions listed in ERISA § 502(a)(5)-(9) do not provide a cause of action for participants and beneficiaries; because Davila is an ERISA participant[7] and Calad is an ERISA beneficiary,[8] neither could have asserted a claim that falls within these subsections.[9] Subsections 502(a)(1)(A) and (4) deal with plan administrators' duties to supply information; they too are irrelevant. Section 502(a)(3) indicates equitable remedies are generally available under ERISA; it includes only "those categories of relief that were typically available in equity," *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), not the damages claims Calad and Davila bring, *id.* at 713. This leaves only two enforcement provisions of § 502(a)[10]—§ 502(a)(2)

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7 *See* 29 U.S.C. § 1002(7) ("The term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization").

8 *See* 29 U.S.C. § 1002(8) ("The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder").

9 *Cf. McClelland*, 155 F.3d at 518.

10 In its entirety, § 502(a) reads,

> (a) Persons empowered to bring a civil action
> A civil action may be brought—
> (1) by a participant or beneficiary—
> (A) for the relief provided for in subsection (c) of this section, or

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> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;
> (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;
> (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;
> (6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (l) of this section;
> (7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);
> (8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or
> (9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the al-

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and (a)(1)(b)—neither of which preempts Calad's or Davila's claims.

1. § 502(a)(2)

Calad and Davila argue that their HMO's were not acting as plan fiduciaries when denying them medical treatment, so § 502(a)(2) cannot cover (or completely preempt) their THCLA claims. We agree.

Section 502(a)(2) allows a plan participant or beneficiary to sue "for appropriate relief under section 1109 of this title." 29 U.S.C. § 1132(a)(2). Section 1109(a) in turn provides:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach

29 U.S.C. § 1109(a).

In *Pegram v. Herdrich*, 530 U.S. 211 (2000), the Court decided that under § 502(a)(2), a patient cannot hold his HMO vicariously liable for its physician's medical malpractice. Although *Pegram* did not decide the precise question before us—whether, under § 502(a)(2), a patient can hold his HMO *directly* liable for its own medical malpractice—its holding is broad enough to apply here.

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leged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

29 U.S.C. 1132(a).

In *Herdrich*, the plaintiff became a patient of Pegram's through her HMO. When Pegram discovered an inflamed mass in Herdrich's abdomen, she did not order an immediate ultrasound; instead, she decided Herdrich would have to wait eight days to be examined at a center fifty miles away; in the meantime, Herdrich's appendix ruptured.

Herdrich sued Pegram for medical malpractice and sued both Pegram and her HMO under ERISA §§ 502(a)(2) and 1109, alleging that the HMO's medical rationing scheme, by which it "reward[ed] its physician owners for limiting medical care, entailed an inherent breach of an ERISA fiduciary duty, because these terms created an incentive to make decisions in the physicians' self- interest rather than in the exclusive interest of the plan participants." *Pegram*, 530 U.S. at 216.

The Court unanimously ruled that Herdrich did not state a cause of action under § 502(a). The Court first categorized Herdrich's claim. HMO's, it explained, made three types of decisions—eligibility decisions, treatment decisions, and mixed eligibility and treatment decisions. *Id.* at 228-29. Eligibility decisions "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Id.* at 228.

Pure eligibility decisions, "simple yes-or-no questions, like whether appendicitis is a covered condition," are likely rare. *Id.* Treatment decisions, "by contrast, are choices about how to go about diagnosing and treating a patient's condition." *Id.* Herdrich's case, the Court concluded, involved "the more common" mixed decision, such as "whether one treatment option is so superior . . . and needed so promptly, that a decision to proceed would meet the medical necessity requirement." *Id.* at 228-29. Claims regarding such "mixed eligibility and treatment decisions," the Court held, do not fall within § 502(a)(2). *Id.* at 231-32.

It seems beyond dispute that Calad's and Davila's claims involve such mixed decisions. CIGNA agrees its plan covers

hospital stays after a hysterectomy, and Aetna agrees its plan includes a range of arthritis drugs, so we are not presented with simple yes-or-no coverage questions. Instead, we are presented with the type of "when and how" medical necessity questions—whether Calad was provided enough treatment (enough days in the hospital) and whether Davila was prescribed the correct treatment (naprosyn instead of Vioxx)—that fall within *Pegram*'s rule. *Id.* at 228-29.

Pegram is distinguishable in one regard: Herdrich claimed her doctor made the erroneous medical decision; Calad and Davila claim their HMO's did. But *Pegram's* reasoning indicates this distinction is immaterial to the § 502(a)(2) analysis.

The *Pegram* Court expressed doubt that "that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231. It contrasted fiduciaries, who must "act solely in the interest of the patient without possibility of conflict," *id.* at 233, with HMO's, whose entire purpose is to balance costs against patient welfare, *id.* at 231-32. "Since inducement to ration care goes to the very point of any HMO scheme," *id.* at 221, treating HMO's as ERISA fiduciaries would entail "nothing less than the elimination of the for-profit HMO," *id.* at 233.

The *Pegram* Court went on to note the potential "mischief' the alternative holding would entail. *Id.* at 236. Such a rule would create a federal body of malpractice law applicable against HMO's and physicians. *Id.* at 235-36. And, because ERISA § 502(a) preempts any overlapping state law, this would create "a puzzling issue of preemption"; it "would seem to be a prescription for preemption of state malpractice law." *Id.* at 236. This could not be so, the Court explained, for "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose," *id.* at 237 (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v.*

Travelers Ins. Co., 514 U.S. 645, 654-55 (1995)), and it was unimaginable that Congress intended ERISA to create a federal common law of medical malpractice. *Id.*

These factors apply with equal force to a claim that an HMO breached its fiduciary duty in denying care. Such a claim demands that the HMO forego its core purpose—rationing care—and act only in the patient's interest. And, such a claim would create a federal body of malpractice law applicable against HMO's. Because *Pegram* is indistinguishable, § 502(a)(2) does not completely preempt Calad's and Davila's THCLA claims.

2. § 502(a)(1)(B)

The Supreme Court has declined to decide whether § 502(a)(1)(B) displaces a medical malpractice claim involving "mixed decisions," *Pegram*, 530 U.S. at 229 n.9, and this circuit has not yet confronted the question.[11] We now con-

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[11] In *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), we held that § 514 preempted a patient's claim that her HMO was medically negligent for refusing to hospitalize her. Section 502(a) preemption is a subset of § 514 preemption. Although any claim that falls within § 502(a) necessarily falls within § 514, claims that fall under § 514 do not necessarily fall under 502(a). *McClelland*, 155 F.3d at 517. Thus, *Corcoran* does not decide our question.

In *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir. 2000), *vacated on other grounds by Montemayor v. Corporate Health Ins.*, 122 S. Ct. 2617 (2002), we ruled that § 514 (and thus § 502(a)(1)(B)) does not preempt a THCLA suit holding an HMO vicariously liable for its doctor's negligence. But we cannot automatically extend *Corporate Health's* holding to suits directly against an HMO. The *Corporate Health* court held

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clude that § 502(a)(1)(B) does not preempt Calad's and Davila's THCLA claims.

Section 502(a)(1)(B) allows a plan participant or beneficiary to bring a civil action "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Calad's and Davila's claims of HMO medical malpractice differ fundamentally from the § 502(a)(1)(B) claims we have recognized. Section 502(a)(1)(B), we have held, creates a cause of action for breach of contract: When a plan administrator incorrectly interprets the plan to deny benefits, the patient may sue to recover the benefits.[12] By contrast, Calad and Davila assert tort claims; they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan.

Dowden v. Blue Cross & Blue Shield. Inc., 126 F.3d 641 (5th Cir. 1997) (per curiam), is on point. The plaintiff's health insurer refused to cover the expenses she incurred treating complications from breast implants. The insurance policy limited coverage to only "medically necessary" treatments, and the plan administrator concluded that Dowden's

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that when a doctor denies treatment, he makes a quality-of-care decision, which escapes ERISA preemption. By contrast, when an HMO denies treatment, it makes a coverage decision, and claims over such a decision are preempted by ERISA. *Id.* at 534-35 & n.24. *But cf. Pegram* 530 U.S. at 228-30 (indicating courts should look to the substance of the decision, not the identity of the decisionmaker, in determining whether ERISA applies).

12 *See, e.g., Gosselink v. Am. Tel. & Telegraph Inc.*, 272 F.3d 722, 726-28 (5th Cir. 2001); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 636 (5th Cir.), *modified*, 979 F.2d 1013 (5th Cir. 1992).

treatment did not fit the plan's definition. *Id.* at 644. Dowden sued under § 502(a)(1)(B), claiming "the plan administrator abused its discretion in interpreting the term 'medically necessary' as expressly defined in the insurance contract," and wrongfully withheld benefits owed to her. *Id.* at 643.

Superficially, this claim resembles Calad's and Davila's: Like Calad and Davila, Dowden claimed she was wrongfully denied medically necessary treatment. But, Dowden asserted a contract claim for contract damages; Calad and Davila assert a tort claim for tort damages. Calad and Davila are not seeking reimbursement for benefits denied them: Calad is not requesting the value of an extra night at the hospital, and Davila is not requesting reimbursement for the more expensive drug the HMO denied.

In deciding Dowden's claim, we were limited to the plan and its definition of "medically necessary." For Calad and Davila, the wording of their plans is immaterial; they invoke an external, statutorily imposed duty of "ordinary care."

Furthermore, this court has treated as given that ERISA provides no cause of action for medical malpractice claims against an HMO. In *Corcoran* we noted the troubling result of our holding that ERISA § 514 bars states from providing such remedies: "The result ERISA compels us to reach means that the [plaintiffs] have no remedy, state or federal, for what might have been a serious mistake."[13] Nor have we ever recognized a claim of HMO medical negligence under § 502(a)(1)(B).

The Third Circuit has reached the same conclusion. In *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3d Cir.

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13 *Corcoran*, 965 F.2d at 1338; accord *id.* at 1333; Note, *Recent Cases*, 114 HARV. L. REV. 1406, 1409 (2001).

1995), the court held that claims that an HMO had failed to exercise reasonable care in providing medical treatment are not completely preempted by § 502(a)(1)(B). The plaintiff complained that her hospital provider had acted negligently in delaying her husband's blood test. This delay led to a late diagnosis of his condition and, she argued, his untimely death. *Id.* Her HMO, she asserted, was vicariously liable for the hospital's malpractice and directly liable for negligence in selecting its medical service providers.

Such a claim, the court explained, was not completely preempted, because it "merely attacked the *quality* of benefits received." *Id.* at 356. "Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the Germantown Hospital refused to perform blood studies on [her husband] because the ERISA plan refused to pay for the studies." *Id.* at 357.

The Third Circuit's more recent decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), reaffirms this conclusion. The plaintiff claimed, *inter alia*, that her HMO "'negligently and carelessly delayed in giving its approval for the necessary surgery which the plaintiff . . . urgently needed.'" *Id.* at 270 (alterations in original). Although the court held that ERISA § 502(a)(1)(B) completely preempted this claim, it grounded its holding in its finding that the claim involved "core administrative function," the type of "pure eligibility decision" as defined by *Pegram* not the type of treatment decision involved in *Dukes*. *Id.* at 274.

CIGNA and Aetna cite *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), for the proposition that Congress intended § 502(a)(1)(B)'s contract action to be the sole remedy available. They argue that patients must pay for services ahead of time and, if the plan administrator denies benefits, sue for reimbursement under § 502(a)(1)(B). Although *Pilot*

Life includes some expansive language that arguably supports CIGNA and Aetna's reading,[14] the Supreme Court's most recent word on the matter, *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002), indicates *Pilot Life* does not sweep so broadly.

In *Pilot Life*, an ERISA participant who was denied benefits sued in state court, asserting common law contract claims. The Court held § 502(a)(1)(B) preempted the claim. ERISA provides a means of collecting benefits and set forth an exclusive list of remedies; states could not create alternative causes of action for collecting benefits that expanded upon ERISA's remedies. *Pilot Life*, 481 U.S. at 54-55; *Rush Prudential*, 122 S. Ct. at 2166.

Since *Pilot Life* the Supreme Court has "found only one other state law to 'conflict' with § 502(a) in providing a prohibited alternative remedy." *Rush Prudential*, *id.* In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court held that "Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement." *Rush Prudential*, 122 S. Ct. at 2166. The *Rush Prudential* Court explained its holding in *Ingersoll-Rand*: "[The] state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for

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[14] *See, e.g.*, *Pilot Life*, 481 U.S. at 54 ("[Congress's] inclusion of certain remedies and exclusion of others . . . would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. . . . 'Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly'" (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

money damages (available in a state tribunal)." *Rush Prudential*, *id.*

We glean from *Rush Prudential* that *Pilot Life's* rule is a narrow one: States may not duplicate the causes of action listed in ERISA § 502(a). This is, essentially, the test employed for "complete preemption." Because the THCLA does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*.

Any doubts we might have are eliminated by *Pegram*'s admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice. *See Pegram*, 530 U.S. at 236-37. We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B). Having concluded that § 502(a) does not completely preempt Calad's and Davila's THCLA claims, we vacate and remand to the district court for proceedings consistent with this decision.

B. Thorn's motion to remand

Aetna cross-appeals the decision to remand Thorn's claims to state court. Except for those cases removed pursuant to 28 U.S.C. § 1443, "[a]n order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise." 28 U.S.C. § 1447(d). On its face, this statute seems to deprive us of jurisdiction over Aetna's cross-appeal. But we read 1447(d) in conjunction with § 1447(c)'s command that "[i]f at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded." 28 U.S.C. § 1367(c). Accordingly, 1447(d) applies only where a district court remands for lack of subject matter jurisdiction; we may review remands based on other grounds. *Things Remembered v. Petrarca*, 516 U.S. 124, 127-28 (1995); *Giles*, 172 F.3d at 336.

Reviewable remand orders are a narrow class of cases, meaning we review a remand order only if the district court "'clearly and affirmatively' relies on a non-§ 1447(c) basis." *Giles*, 172 F.3d at 336. The district court explained that it had supplemental jurisdiction over Thorn's claim, but it was exercising its discretion under 28 U.S.C. § 1441(c) to remand. As in *Giles*, "the court affirmatively gave a non-§ 1447(c) reason for remanding and gave no indication that it believed it lacked subject matter jurisdiction." *Id.* Accordingly, "we review the district court's exercise of its discretion to remand supplemental . . . state law claims." *Id.*

The district court held that even though Thorn stated only state law causes of action, it had supplemental jurisdiction over his claims, because they were joined to Calad's claims. Thus, the court's jurisdiction over Thorn's claims depended on its removal power over Calad's claims.[15] But, as we have explained, the district court never had removal jurisdiction over Calad's claims. Consequently, it never had subject matter over Thorn's claims, so remand was mandatory, not discretionary.[16]

C. The Roarks' motion to remand

The Roarks' original complaint, filed in state court, stated claims under the THCLA, the DTPA, the Texas Insurance Code, and common law breach of good faith, fair deal-

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15 *See* 28 U.S.C. § 1441(c) (hinging removal of supplemental claims on the existence of "a separate and independent claim or cause of action within the jurisdiction conferred by section 1331").

16 *Avitts v. Amoco Prod. Co.*, 53 F.3d 690, 693 (5th Cir. 1995) (explaining that if district court never had original jurisdiction over any federal claim, it could not have exercised supplemental jurisdiction over the joined state claims and was required to remand).

ing, and contract. Humana removed, citing ERISA preemption, and the Roarks moved to remand. Only after the district court affirmed the removal, concluding ERISA § 502(a) completely preempted the Roarks' DTPA and insurance claims, did the Roarks amend their complaint to state only THCLA claims. The Roarks made a second motion to remand, which the district court again denied; the Roarks appeal only the second denial.

If, at the time of removal, the complaint stated at least one cause of action completely preempted by § 502(a), the district court could have asserted jurisdiction over the entire case, including any claims only conflict-preempted by ERISA § 514 and any state law claims. *See* 28 U.S.C. § 1441(c);[17] *Giles*, 172 F.3d at 337-38.[18] Although the

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17 Section 1447(c) provides,

> Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

28 U.S.C. § 1447(c).

18 In *Giles* we explained,

> Hence, when a complaint raises state causes of action that are completely preempted, the district court may exercise removal jurisdiction. When a complaint contains only state causes of action that the defendant argues are merely conflict-preempted, the court must remand for want of subject matter jurisdiction. When a complaint raises both completely-preempted claims and arguably conflict-preempted claims, the court may exercise removal jurisdiction over the completely-

[Footnote continued on next page]

Roarks do not appeal the initial holding that § 502(a) completely preempts some of their original claims, we must examine it on our own initiative, because this question determines whether the district court had subject matter jurisdiction. *McClelland*, 155 F.3d at 511, 518 n.39. We review this preemption question *de novo*, *id.* at 511, and conclude the district court did have jurisdiction.

Count six of the Roarks' original complaint alleges breach of contract: "By virtue of the policies provided to the Plaintiffs, Defendants assumed obligations, as outlined in the Member Materials and other documents provided to policy enrollees like the Roarks, to provide medically necessary treatment . . . . Defendants breached this promise to Mrs. Roark, causing her to suffer direct and serious damage." The Roarks assert that the plan's term "medically necessary treatment" includes VAC treatments.

The answer turns on interpreting the plan's language, not on applying an external, statutorily imposed standard of ordinary care. Because this is precisely the type of contract claim we recognize under § 502(a)(1)(B), *see supra* part II.A.2, this claim is completely preempted under ERISA.

This establishes that the district court had the power to entertain the Roarks' suit; it does not necessarily mean the court acted properly in doing so. The Roarks amended their complaint to state only THCLA claims, then filed a second remand motion, arguing that because all federal claims had been dismissed, 28 U.S.C. § 1367 required the court to remand the remaining supplemental state law claims. The dis-

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[Footnote continued from previous page]

> preempted claims and supplemental jurisdiction (formerly known as "pendant jurisdiction") over the remaining claims.

Giles, 172 F.3d at 337-38.

trict court ruled that the THCLA claims also were completely preempted under ERISA, so it had original jurisdiction over them and retained the case.

Because ERISA does not completely preempt the Roarks' THCLA claims, *see supra* part II, the district court had only supplemental, not original, jurisdiction over the Roarks' THCLA claims. "We review a district court's decision to retain jurisdiction over pendant [i.e., supplemental] state law claims for abuse of discretion." *McClelland*, 155 F.3d at 519; *see also* § 1367.

Section 1367(3) allows a district court to "decline to exercise supplemental jurisdiction over a claim . . . if . . . the district court has dismissed all claims over which it has original jurisdiction." 28 U.S.C. § 1367(3). The district court should evaluate whether remand furthers "the values of economy, convenience, fairness, and comity." *Carnegie-Mellon Univ. v. Cohill*, 484 U.S. 343, 351 (1988); *accord Brown v. Southwestern Bell Tel. Co.*, 901 F.2d 1250, 1254-55 (5th Cir. 1990).

III. Dismissal of the Roarks' claims

The district court dismissed the Roarks' THCLA claims under rule 12(b)(6), citing ERISA § 514 preemption. We review a rule 12(b)(6) dismissal *de novo*. *E.g.*, *Oliver v. Scott*, 276 F.3d 736, 740 (5th Cir. 2002).

ERISA § 514 preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a). We have spilled much ink over the past few decades trying to interpret this statute. By contrast, our answer today is short and direct: Our decision in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), is on point. Although the Supreme Court has since cast doubt on *Corcoran*'s validity, we do not write on a clean slate. Our rule of orderliness prevents

one panel from overturning the decision of a prior panel, so any relief for the Roarks must come from an en banc panel of this court or the Supreme Court. *Teague v. City of Flower Mound*, 179 F.3d 377, 383 (5th Cir. 1999).

Corcoran is factually indistinguishable from the Roarks' case. There, the HMO ignored its doctor's recommendation to hospitalize Mrs. Corcoran or monitor her pregnancy around the clock; instead it provided the less expensive treatment of ten hours a day of home nursing. *Corcoran*, 965 F.2d at 1324. While no nurse was on duty, Corcoran miscarried. *Id.* She sued her HMO, alleging its negligence caused her baby's wrongful death. *Id.*

We rejected both the HMO's "position that no part of its actions involve[d] medical decisions" and Corcoran's position "that no part of [her HMO's] actions involve[d] benefit determinations." *Id.* at 1332. In actuality, we explained, the HMO "makes benefit determinations as part and parcel of its mandate to decide what benefits are available under the [ERISA] plan." *Id.* "[F]rom this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination." *Id.*

Such a claim, we reluctantly concluded, was preempted under § 514. We recognized the possible harm our ruling created: ERISA provided no cause of action for medical malpractice; if ERISA also preempted all state medical malpractice claims, patients such as the Corcorans would be left with no remedy for potentially serious mistakes. *Id.* at 1338. But, we were bound by Supreme Court precedent, which at that time articulated an expansive view of ERISA preemption.

For example, we cited *Ingersoll-Rand* for the proposition that § 514's broad "relates to" language negated the normal rules of preemption. We would not assume that preemption was less likely in areas of "traditional state authority."[19] And, based on the broad language of *Pilot Life*, *Ingersoll-Rand*, and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), we concluded that even attenuated and indirect effects on an ERISA plan are enough to bring a statute within § 514 preemption. *Corcoran*, 965 F.2d at 1328-29, 1338 n.20.

Since then, the Supreme Court has curtailed the scope of § 514 preemption, most notably in a "trilogy" of cases between 1995 and 1997. The first case, *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), involved a New York statute requiring hospitals to collect surcharges from patients insured by a commercial carrier but exempting HMO's that provided open enrollment coverage. The Second Circuit had held that such surcharges "related to" ERISA plans: Many of these HMO's contracted with ERISA plans, and the surcharge, by affecting these HMO's' economic incentives, had an impact on plan structures.

The Court reversed in a unanimous opinion. The state statute's "indirect economic influence," the Court explained, "does not bind plan administrators to any particular choice." *Id.* at 659. It only alters "the relative costs of competing insurance to provide them," *id.* at 660, and this does not run afoul of ERISA preemption.

Two years later, a unanimous Court handed down *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.,*

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19 *Corcoran*, 965 F.2d at 1334, *see also Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1468 (5th Cir. 1986).

N.A., Inc., 519 U.S. 316 (1997). California had enacted a law that required payment of prevailing wages to employees in apprenticeship non-state approved programs but allowed lower wages for apprentices participating in state approved programs. The Court held that because the law was indifferent to ERISA coverage (state-approved programs did not have to be ERISA programs), the law did not make "reference to" such plans. *Id.* at 325.

The fact that "most state-approved apprenticeship programs . . . appear to be ERISA programs" was immaterial. *Id.* at 327 n.5. Nor did California's law have a "connection with" ERISA plans. It did not bind plans, legally or practically, to a given result; it only provided economic incentives to alter their structure. *Id.* at 329. Most notably, the Court explicitly returned to a traditional preemption analysis: ERISA's "relates to" language did not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by the Federal Act." *Id.* at 331 (internal quotation marks omitted).[20]

The last of the trilogy, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997), held that ERISA did not preempt New York's tax on gross receipts for patient services at health care facilities. The Court acknowledged that the tax had a direct effect on ERISA plans (in fact, it eschewed any distinction between direct and indirect effects), but still upheld the statute.

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20 Justice Scalia, in a concurrence in which Justice Ginsburg joined, urged the Court to "acknowledge[ ] that our first take on this statute was wrong; that the 'relate to' clause . . . is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies." *Id.* at 336 (Scalia, J., concurring).

The trilogy undermines *Corcoran* in two important ways. First, the Court established that traditional preemption rules apply under ERISA. Thus, courts should presume ERISA does not preempt areas such as "general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. Second, the Court held that a state law's economic impact (direct or indirect) on plan structures is not enough to trigger § 514 preemption.

The Court's *dictum* in *Pegram* gives further reason to doubt that ERISA preempts medical malpractice claims such as the Roarks'. In holding that the plaintiff did not state a claim under 502(a)(2), the Court, 530 U.S. at 236-37, expressed disbelief that ERISA preempts such claims:

> To be sure [*Travelers*] throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA.

Pegram, 530 U.S. at 236-37.

Furthermore, after *Pegram*, *Corcoran*'s rule creates perverse incentives for HMO's. If a doctor fails to recommend treatment, the patient may sue the doctor and HMO under state law. If the doctor recommends treatment, and the HMO denies coverage, the patient has no remedy. *Corcoran*, 965 F.2d at 1338. In this circuit, HMO's can escape all liability if they instruct their doctors to recommend every possible treatment and leave the real decision to HMO administrators. It is difficult to believe that one of Congress's goals in passing ERISA was to shift medical judgments from doctors to plan administrators.

If we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case against ERISA preemption. But, as a panel we are bound by *Corcoran*. Accordingly, we affirm with respect to the Roarks.

In summary, the judgment in No. 01-10831, regarding the Roarks, is AFFIRMED. The judgment in No. 01-10891 is REVERSED in regard to Calad and AFFIRMED in regard to Thorn. The judgment in No. 01-10905 is REVERSED in regard to Davila. All these matters are REMANDED to the respective district courts for further proceedings, if any, that may be called for by this opinion.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

[Filed June 29, 2001]

JUAN DAVILA	§	
	§	
VS.	§	ACTION NO.
	§	4:00-CIV-1855-Y
AETNA U.S. HEALTHCARE	§	
INC., and AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.	§	

ORDER DENYING MOTION TO REMAND AND GRANTING MOTION TO DISMISS

Pending before the Court is Plaintiff's Motion to Remand, which was filed in this cause on January 25, 2001. Also pending before the Court is Defendants' Rule 12(b)(6) Motion to Dismiss for Failure to State a Claim Upon Which Relief Can Be Granted, which was filed on February 28. After reviewing all of the briefs regarding these motions and the applicable law, the Court concludes that Plaintiff's motion should be denied, and Defendants' motion should be granted, for the reasons urged by Defendants.

Plaintiff originally filed suit against Defendants in the 67th Judicial District Court of Tarrant County, Texas, asserting a claim under the Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE § 88.001, *et seq.* (Vernon Supp. 2001). Plaintiff contends that Defendants, who administer

health-care-benefits claims under a plan established by Plaintiff's employer, negligently and wrongfully practiced inferior medicine through the use of their prescription-drug formulary. Specifically, Plaintiff complains that although his doctor wanted to prescribe the drug "Vioxx" for Plaintiff's arthritis pain, Defendants refused to cover the medication. (Pl.'s Pet. at 1-2.) Defendants' refusal was based upon its prescription-drug formulary, which was developed through their utilization-review program. (Pl.'s Pet., Ex. 2 to Ex. A.) Under this formulary, coverage for Vioxx is not provided unless the insured has a "contraindication, intolerance, allergy to or a documented adequate trial of at least two (2) formulary (non-steroidal anti-inflammatory drugs]." (Pl.'s Pet., Ex. 2 to Ex. A.) Consequently, Plaintiff's doctor instead prescribed naprosyn for Plaintiff's arthritis pain, which allegedly caused Plaintiff to suffer bleeding ulcers that nearly resulted in a heart attack and required his hospitalization in critical care for several days. (Pl.'s Pet. at 5.)

Defendants removed Plaintiff's claim to this Court, contending that federal-question jurisdiction exists because Plaintiff's state-law claim is completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA"). As a result, Defendants also request that Plaintiff's state-law claim be dismissed and that he be required to assert his claim under ERISA instead. Plaintiff seeks remand, urging that ERISA does not completely preempt his claim and that, as a result, federal-question jurisdiction is lacking and removal therefore was improper.

Defendants, as the removing parties, have the burden of establishing that this Court has jurisdiction over Plaintiffs' claims. *See Carpenter v. Wichita Falls Indep. Sch. Dist.*, 44 F.3d 362, 365 (5th Cir. 1995). The question of whether federal jurisdiction exists is generally determined according to the "well-pleaded-complaint rule." *Franchise Tax Bd. v.*

Construction Laborers Vacation Trust, 463 U.S. 1, 9-10 (1983). Under this rule, "federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint; a federal defense does not confer subject-matter jurisdiction." *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 160 (3d Cir. 1999). Unquestionably, Plaintiff's petition does not assert a federal claim on its face.

Defendants contend that federal-question jurisdiction nevertheless exists, and that removal was therefore proper, based on the complete-preemption doctrine. The complete-preemption doctrine "functions as an exception to the well-pleaded complaint rule; 'Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character.'" *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 336-37 (5th Cir. 1999) (quoting *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987)). If the state law upon which a plaintiff's claim is based is completely preempted, a federal question is presented regardless of how the plaintiff couches the claim, and removal to federal court is proper. *Id.* at 337. Nevertheless, complete preemption applies only in extraordinary circumstances; it requires a clear expression of congressional intent to make a cause of action removable. *Aaron v. National Union Fire Ins. Co.*, 876 F.2d 1157, 1163 (5th Cir. 1989), *cert. denied*, 493 U.S. 1074 (1990).

Complete preemption occurs under ERISA when a state-law claim fits within the scope of the civil-enforcement provision found in section 502 of ERISA. *See* 29 U.S.C. § 1132; *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 354 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995).

ERISA's civil-enforcement provision establishes a federal cause of action whenever an ERISA-plan participant or

beneficiary seeks to recover benefits due or to enforce or clarify rights under the plan. 29 U.S.C. § 1132(a)(1)(B).[1]

ERISA also contains a second type of preemption known as "ordinary" or "conflict" preemption. Section 514 of ERISA provides that ERISA's provisions "supersede any and all State common laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although section 514's "conflict" preemption has been broadly construed, it nevertheless is defensive in nature and therefore provides no basis for removal jurisdiction under the well-pleaded-complaint rule. *Giles*, 172 F.3d at 337. Thus, "when the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding [§ 514(a)] preemption." *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995). Rather, it must remand to state court, and that court will resolve the § 514(a) preemption issue.

Plaintiff contends that his claim challenges only the quality of care he received as a result of Defendants' participation, through its formulary, in his treatment. When a plaintiff attacks only the quality of care he has received under an ERISA plan, that is, when he attacks decisions made about his medical treatment, his claim does not arise under § 502 of ERISA and thus is not completely preempted. *See Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d. 266, 272-73 (3d Cir. 2001). "On the other hand, a claim alleging that an

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[1] Additionally, a civil action may be brought under ERISA to obtain relief for a breach of the fiduciary duties or violations of the statutory reporting requirements established by ERISA. 29 U.S.C. § 1132(a)(1)(A) & (a)(2).

HMO declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits" and, as a result, would be completely preempted under ERISA. *Id.* at 273. Thus, the Court must determine whether Plaintiff's "claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action." *Id.*

Despite Plaintiff's attempt to pepper his petition with quality-of-care and medical-treatment allegations, the Court concludes that Plaintiff's claim, fairly construed, actually challenges the administration of health benefits under an ERISA plan. Plaintiff challenges Defendants' adherence to its prescription-drug formulary despite his doctor's recommendation. Plaintiff claims that Defendants refused to provide coverage for the drug his doctor recommended and instead required that he first try a less-expensive drug that caused side effects. Plaintiff contends that Defendants' formulary policies amounted to the improper practice of medicine. What Plaintiff really challenges, however, is Defendants' determination regarding which particular drugs are covered under the plan and the circumstances of that coverage. The Court concludes that, distilled to its essence, Plaintiff's claim against Defendants concerns their administration of benefits under the plan, rather than the quality of care he received. As a result, his state-law claim is completely preempted by ERISA, federal-question jurisdiction exists, and removal was proper.

Normally, the Court would dismiss Plaintiff's state-law claim but grant him leave to file an amended complaint asserting a claim under ERISA. Plaintiff's response to Defendants' Motion to Dismiss indicates, however, that Plaintiff does not desire to pursue an ERISA claim. *See* Pl.'s Resp. to

Defs.' Mot. to Dismiss and Reply to Defs.' Resp. to Pl.'s Mot. to Remand at 2-3. As a result, Plaintiff's state-law claim will be dismissed without leave to amend.

It is, therefore, ORDERED that Plaintiff's Motion to Remand [document number 5-1] is DENIED.

It is further ORDERED that Defendants' Motion to Dismiss [document number 13-1] is GRANTED. Plaintiff's state-law claim is DISMISSED WITH PREJUDICE to the refiling of same.

SIGNED June 29, 2001.

/s/
TERRY R. MEANS
UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 01-10831

[Filed April 15. 2003]

ROBERT ROARK; ROBERT ROARK, on behalf of the Estate of Gwen Roark.

Plaintiffs – Appellants

v.

HUMANA INC; HUMANA HEALTH PLAN OF TEXAS INC, doing business as Humana Health Plan of Texas (Dallas), doing business as Humana Health Plan of Texas (San Antonio), doing business as Humana Health Plan of Texas (Corpus Christi); HUMANA HMO TEXAS INC

Defendants - Appellants

Case No. 01-10891

RUBY R CALAD

Plaintiff - Appellant-Cross-Appellee

and

WALTER PATRICK THORN

Plaintiff - Cross-Appellee

v.

CIGNA HEALTHCARE OF TEXAS INCORPORATED, doing business as Healthsource, doing business as Cigna Corporation

Defendant - Appellee

AETNA US HEALTHCARE, AETNA U S HEALTHCARE OF NORTH TEXAS, INC

Defendants - Appellees-Cross-Appellants

Case No. 01-10905

JUAN DAVILA

Plaintiff - Appellant

v.

AETNA US HEALTHCARE, INC; AETNA US HEALTHCARE OF NORTH TEXAS, INC

Plaintiffs - Appellants

Defendants - Appellees

Appeals from the United States District Court for the Northern District of Texas, - Dallas

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ON PETITION FOR REHEARING AND REHEARING EN BANC

(Opinion 9/17/02, 5 Cir., _____, _____ F.3d _____)

Before SMITH and BENAVIDES, Circuit Judges.*

PER CURIAM:

(X) The Petition for Rehearing filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc filed by Aetna Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is also DENIED.

( ) The Petition for Rehearing filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is DENIED and the court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service not having voted in favor, (FED. R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor, Rehearing En Banc filed by Aetna US Healthcare Inc. and Aetna US Healthcare of North Texas Inc. is DENIED.

ENTERED FOR THE COURT:

/s/ JERRY E. SMITH
United States Circuit Judge

REHG-4A

*Judge Parker, a member of the panel, is retired and did not participate in consideration of rehearing. This matter is decided by a quorum pursuant to 28 U.S.C. § 46(d).

Judge Jones is recused and did not participate in the consideration of rehearing.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

[Filed June 29, 2001]

JUAN DAVILA	§	
	§	
VS.	§	ACTION NO.
	§	4:00-CIV-1855-Y
AETNA U.S. HEALTHCARE	§	
INC., and AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.	§	

FINAL JUDGMENT

In accordance with the order issued this same day and Federal Rule of Civil Procedure 58,

It is hereby ORDERED, ADJUDGED, and DECREED that all claims are hereby DISMISSED WITH PREJUDICE to their refiling. All costs of Court under 28 U.S.C. § 1920 shall be borne by Plaintiff.

SIGNED June 29, 2001.

/s/
TERRY R. MEANS
UNITED STATES DISTRICT JUDGE

APPENDIX E

The Supremacy Clause of the Constitution of the United States provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution of Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

APPENDIX F

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER 1—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * *

§ 1132. Civil Enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6) of subsection (c) or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021, of this title or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of title 42.

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other

person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 1145 in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 by a party in interest

with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of title 26.

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this chapter by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of title 26.

(m) Penalty for improper distribution. In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount

equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

* * * * *

§ 1144. Other laws.

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which

any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited.

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

APPENDIX G

TEXAS CIVIL PRACTICE AND REMEDIES CODE
TITLE 4. LIABILITY IN TORT
CHAPTER 88. HEALTH CARE LIABILITY

§ 88.001. Definitions

In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness

insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed

care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

§ 88.002. Application

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being li-

censed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

§ 88.003. Limitations on Cause of Action

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with or otherwise complies with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsections (c) and (d).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) A review conducted under Subsection (c) as requested by a health insurance carrier, health maintenance organization, or managed care entity must be performed in accordance with Article 21.58C, Insurance Code. The health insurance carrier, health maintenance organization, or managed care entity requesting the review must agree to comply with Subdivisions (2), (3), and (4), Section 6A, Article 21.58A, Insurance Code.

(e) Subject to Subsection (f), if the enrollee has not complied with Subsection (a), an action under this section shall

not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(f) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (e) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (e).

(g) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(h) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

APPENDIX H

CAUSE NO. 067-185326-00

JUAN DAVILA	§	IN THE
	§	DISTRICT COURT
Plaintiff,	§	
	§	
	§	TARRANT
v.	§	COUNTY, TEXAS
	§	
AETNA U.S. HEALTHCARE INC., AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.	§	
	§	
	§	
	§	
	§	___ JUDICIAL
Defendants.	§	DISTRICT

PLAINTIFF'S ORIGINAL PETITION

TO THE HONORABLE JUDGE OF SAID COURT:

NOW COMES PLAINTIFF, Juan Davila, to file this his Original Petition against Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. (collectively "Aetna" or "Defendants"), and would respectfully show the Court as follows.

I.

DISCOVERY CONTROL PLAN

1. Discovery is intended to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

II.

OVERVIEW

2. This claim is brought pursuant to the Texas Health Care Liability Act, Tex. Civ. Prac. & Rem. Code §§ 88.00, *et seq.*, complaining of AEtna's negligent and wrongful use of its prescription drug formulary policies to practice improper medicine; that is, to divert Juan Davila from access to prescription medications that his treating physician believes are most safe and effective. The Vioxx Juan Davila's treating physician wanted to prescribe is on AEtna's formulary. However, through its formulary policies, which amount to the improper practice of medicine, AEtna directly and adversely affected and influenced the *quality* of the medical care and treatment provided to Juan Davila, forcing his treating physician to first prescribe a less effective drug with worse side effects than Vioxx. Juan Davila suffered one of the worst of these side effects, thanks to Aetna, a bleeding ulcer that almost killed him.

A. AEtna's Denial of Juan Davila's Treating Physician's Recommended Prescription Treatment

3. In Juan Davila's case, despite the recommendations and protests of his treating physician, AEtna refused to provide Vioxx for relief of the pain caused by Juan Davila's arthritis his treating physician prescribed, *despite Vioxx being on the AEtna formulary.* Instead, pursuant to AEtna's own formulary policies, Juan's primary care physician was forced to prescribe naprosyn, a cheaper generic pain reliever. Naprosyn has also been shown in studies to have incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforation of the stomach, significantly higher than Vioxx.

4. As a result of AEtna's naprosyn substitution, Juan Davila began to suffer bleeding ulcers, ultimately resulting in his being rushed to the emergency room on July 20, 2000 after a near-heart attack. Both a specialist and a nurse at the

hospital told the Juan Davila that Naprosyn sometimes caused these problems.

5. AEtna's adherence to its own prescription formulary policies, despite the recommendations of his own creating physician, directly affected and influenced the quality of care provided to Juan Davila, culminating in his hospitalization and near-death, the effects of which he continues to suffer.

III.

PARTIES

6. Plaintiff, Juan Davila, is an individual who resides in Denton, Texas.

7. Defendant AETNA U.S. HEALTHCARE, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons Freeway, Suite 300, Dallas, Texas 75207 with citation and a copy of this Petition attached thereto.

8. Defendant AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons Freeway, Dallas, Texas 75207 with citation and a copy of this Petit ion attached thereto.

IV.

JURISDICTION & VENUE

9. Jurisdiction is proper in this Court because the amount in controversy in this case exceeds the jurisdictional limits of State District Courts in Texas.

10. Venue is proper in Tarrant County, Texas because AEtna maintains a principal office in Tarrant County. *See* Tex. Civ. Prac. & Rem. Code § 15.002(a)(3). Specifically, while

AEtna has offices in other parts of the State of Texas, AEtna maintains a principal place of business in Tarrant County, Texas, where decision makers of substantially equal responsibility and authority conduct business.

V.

FACTS

A. AEtna's Prescription Drug Formulary Policies Directly Influenced and Controlled the Treatment Afforded Juan Davila and the Quality of that Care

11. Juan Davila is 48 years old, and a resident of Ponder, Texas. Mr. Davila obtained his AEtna PPO health coverage through his employer, Monitronics, where he screens house-signaled house alarms. Monitronics played no role in determining which medications are included in the AEtna drug formulary; instead, drug formulary medical policy is determined solely by AEtna, based largely on cost factors rather than effectiveness and potential side effects and harm to patients.

12. Juan is a post-polio patient, diabetic and suffers from arthritis. In April of 2000, Dr. Joseph Lopez, Juan's primary care physician, prescribed Vioxx to ease the pain and discomfort Juan was having associated with his arthritis. Compared to the other drugs on the AEtna formulary, Vioxx has been shown in studies to have a lower incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforation of the stomach. When Juan tried to fill the prescription, however, he was informed that his insurer, AEtna PPO, would not fill it, *even though Vioxx is on the AEtna formulary.*

13. In order to save its shareholders money, AEtna determined to dictate the practice of medicine delivered to its members. AEtna informed Dr. Lopez that Juan must be placed in a "step program" to get to Vioxx. Before Vioxx

would be permitted, Juan would have to be placed on two (2) different medications, and suffer a detrimental reaction to these drugs or show no signs of improvement. *Only then* would Juan be medically evaluated by AEtna for Vioxx. Despite Dr. Lopez's protests, AEtna's decision to refuse his prescription for Vioxx was final, and naprosyn was prescribed.

14. After being on naprosyn for several weeks, Juan began to experience weakness and related symptoms in late June. He was rushed to the emergency room on July 20, 2000, where it was discovered that he suffered from bleeding ulcers, resulting in a near-heart attack. In the emergency room, Juan was administered seven units of blood; indeed, doctors at the emergency room told Juan hew as within hours of dying from internal bleeding.

15. Juan was kept in critical care for five (5) days during which time a specialist and a nurse said the Naprosyn sometimes causes these types of problems. Juan was subsequently readmitted to the hospital for further complications, but is currently recovering at home. As a result of AEtna's improper dictation of the practice of medicine in delaying the prescription of Vioxx, and forcing on Juan Davila the cheaper but inappropriate naprosyn, Juan will not be able to take any other pain medication for his arthritis-related pain which has to be absorbed through the stomach, including aspirin.

VI.

CAUSE OF ACTION

A. Texas Health Care Liability Act

16. Plaintiff hereby incorporates Paragraphs 1 through 15 above, inclusive.

17. This claim is brought pursuant to §§ 88.001, *et seq.*, of the Civil Practice & Remedies Code. As described above, AEtna failed to use ordinary care in influencing, controlling,

participating in and making health-care treatment decisions regarding Juan Davila through its adherence to its prescription drug formulary policies. The AEtna Defendants each served as managed care entities exercising control and/or influence over the medical care received by Juan Davila. By definition, a "managed care entity" includes any entity which delivers, administers, or assumes risk for, health care services. *See* Tex. Civ. Prac. & Rem. Code, § 88.001(8).

18. Medical services were actually provided to plaintiff by the Aetna Defendants. Through its formulary policies, AEtna controlled, influenced, participated in and made decisions which affected the quality of the diagnosis, care, and treatment provided to Plaintiff, violating the duty of ordinary care set forth in §§ 88.001 and 88.002. Such violation of ordinary care was the proximate cause of Plaintiffs damages, as described herein.

19. The AEtna Defendants, either jointly or singularly as the evidence may show, failed during the time in which they were influencing, controlling, participating in or providing health care treatment decisions to Juan Davila to provide him with appropriate quality care within the managed care standard of care for the treatment of his arthritis. Additionally, the AEtna Defendants put systems in place such as to make such sub-standard care more likely than not.

20. Each and every one of the foregoing acts of omission and commission, taken separately and collectively, constituted the direct and proximate cause of injuries suffered by Plaintiff. Accordingly, Plaintiff brings suit for his damages pursuant to § 88.001 *et seq.* of the Texas Civil Practices and Remedies Code. AEtna's actions with regard to the management of Juan Davila's care through its prescription drug formulary policies constitutes negligence that has been the proximate cause of significant damages to Plaintiff herein.

21. Plaintiff has fulfilled all requirements of § 88.001, *et seq.*, which are prerequisites to this suit. The expert re-

port of Joseph Lopez, M.D., is attached hereto and incorporated herein by reference, as required by Tex. Civ. Prac. & Rem. Code § 88.002(k). The independent review set forth in § 88.003 was of nc benefit prior to filing this suit and is of no benefit now—the harm has already occurred.

VII.

DAMAGES

22. Plaintiff hereby incorporates paragraphs 1 through 21 above, inclusive.

23. The foregoing aces and omissions, taken separately and collectively, were the direct and proximate cause of the harm caused to Plaintiff. Accordingly, Plaintiff sues for:

> Lost earnings, both past and future Pecuniary loss, both past and future Physical pain and mental anguish, both past and future

24. Plaintiff does not seek recovery for denial of any benefits, nor is he seeking payment for Vioxx. Notably, Mr. Davila's injuries cannot be remedied by any retroactive authorization or payment of any benefit. Plaintiff seeks relief based on Defendants' failure to use ordinary care in "influencing," "controlling," "participating in" and making health care treatment decisions through its prescription drug formulary medical policies, where care was actually provided.

VIII.

GROSS NEGLIGENCE/PUNITIVE DAMAGES

25. Plaintiff hereby incorporates Paragraphs 1 through 24 above, inclusive.

26. Plaintiff was the victim of a knowing, calculated scheme whereby the Aetna Defendants increased their profits by controlling and influencing the medically necessary care for patients such as Juan Davila through their prescription

drug formulary policies. The evidence will show that AEtna had both actual and subjective knowledge that their scheme involved an degree of risk which would lend to the serious injury or death of AEtna members such as Plaintiff. Nonetheless, AEtna put in place and enforced their formulary policies and system of health care delivery, with conscious indifference to the rights, safety and welfare of others and the injury such a system which would cause. Therefore, Plaintiff seeks punitive damages, pursuant to § 41.001, *et. seq.*, of the Texas Civil Practices & Remedies Code, against AEtna.

IX.

PLAINTIFF'S CLAIMS FOR DAMAGES NOT BARRED BY ART. 4590i, §§ 11.02-11.04, or CPRC § 41.008

27. Plaintiffs health care liability claims for damages against AEtna are not barred or limited by the Texas Medical Liability and Insurance Improvement Act, Tex. Rev. Civ. Stat. Ann. Art. 4590i, §§ 11.02, 11.03, and 11.04 (Vernon Supp. 1995) ("the Act"), which attempt to limit the maximum liability of physicians and certain health care providers, for medical or health care negligence in malpractice or health care liability claims only for the reasons that:

(a) Sections 11.02(a), 11.03, and 11.04 are arbitrary, unreasonable, and in violation of plaintiffs' rights to due process of law and/or equal protection of the laws under the Fifth and Fourteenth Amendments to the United States Constitution, and Article 1, sections 3 and 19 of the Texas Constitution, because (1) the damage limitation invidiously discriminates between seriously injured or death victims of medical or health care negligence or malpractice. (2) the damage limitation grants health care providers special immunity from damages over other tort-feasors, (3) the damage limitation fails to provide a reason-

able substitute for malpractice victims or their heirs who suffer damages in excess of that amount, (4) the damage limitation discriminates between medical malpractice victims and victims of other torts in general, (5) article 4590i and/or the damage limitation did not have a rational basis or was not justified in view of the absence of a so-called "medical malpractice crisis" or "medical malpractice insurance crisis," and (b) alternatively, the alleged crisis no longer exists;

(b) Sections 11.02, 11.03, and 11.04 are in violation of the open courts clause, article I, section 3, of the Texas Constitution for the reasons stated by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988);

(c) Sections 11.02, 11.03 and 11.04 are in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article I, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages;

(d) Sections 11.02, 11.03, and 11.04 unduly and unnecessarily restrict the plaintiffs' right to deal with the so-called "crisis" in violation of Tex. Rev. Civ. Stat. Ann. Art. 4590i, section 1.02(b) & (c); and

(e) Sections 11.02, 11,03, and 11.04 were declared unconstitutional by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988). They are thus dead statutes because they can only be in force and effect if they are passed again, in a constitutional form, by the Texas Legislature. These statutes cannot be "resurrected" by the courts. Thus, sections 11.02, 11.03, and 11.04 are not in force and effect, and do not operate to limit the plaintiffs' damages.

(f) In the alternative, the Defendants are not "providers" under the Act.

28. Further, Plaintiff s claims for exemplary damages against Defendants are not barred or limited by Texas Civil Practices & Remedies Code § 41.008, which attempts to limit The liability of Defendants for exemplary damages, for the reasons that:

(a) Section 41.008 is in violation of the open courts clause, article 1 section 3, of the Texas Constitution for the reasons stated b y the Texas Supreme Court *in Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); and

(b) Section 41.008 is in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article I, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages.

X.

PREJUDGMENT INTEREST

29. Plaintiff also seeks prejudgment interest as a matter of law on his damages described herein calculated in accordance with Tex. Rev. Civ. Stat., art. 5069-1.05, or upon such other terms, conditions, and rate, as allowed by law.

30. Plaintiff further requests the Court to take judicial notice of the rate of interest published by the Texas Consumer Credit Commission in the Texas Register on the date of judgment in this cause for purposes of calculating the rate of prejudgment interest to be awarded to plaintiffs in this cause, or such other periods of time, and such other rate or rates of interest allowed by law for determination of prejudgment interest.

XI.

DEMAND FOR JURY TRIAL

31. Plaintiff hereby demands a jury trial of the above entitled and numbered cause. The Plaintiff is entitled to a trial by jury in the above cause pursuant to the Texas Constitution, Art. I, Section 15, and Tex. R. Civ. P. 216.

32. Plaintiff sues Defendants jointly and singularly.

XII.

PRAYER

WHEREFORE, PREMISES CONSIDERED, Plaintiff prays that he has judgment against all Defendants named herein, as follows:

a. That Plaintiff recover judgment from Defendants for Plaintiff's actual damages, in a total sum in excess of the jurisdictional limits of this court;

b. The Plaintiff recover judgment from the AEtna Defendants for exemplary damages, in a total sum in excess of the jurisdictional limits of this court;

c. That Plaintiff recover prejudgment interest on the amount accrued on the damage amount(s) at the highest legal rate allowed by law;

d. That Plaintiff recover post-judgment interest on the due amount at the highest legal rate from the date of judgement until it is paid;

e. That plaintiff recover all costs of court;

f. For such other and further relief, at law or in equity, to which he may show himself justly entitled.

Respectfully submitted,

/s/

George Parker Young
State Bar No. 22184750
Adam J. Williams
State Bar No. 24013753

FRIEDMAN, YOUNG, SUDER
& COOKE
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Fort Worth, Texas 76102
Telephone: (817) 334-0400
Facsimile: (817) 334-0401

ATTORNEYS FOR PLAINTIFF

[Exhibit A to Original Petition]

CAUSE NO. _____

JUAN DAVILA	§	IN THE
	§	DISTRICT COURT
Plaintiff,	§	
	§	
v.	§	TARRANT
	§	COUNTY, TEXAS
AETNA U.S. HEALTHCARE INC., AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.	§	
	§	____ JUDICIAL
Defendants.	§	DISTRICT

AFFIDAVIT OF JOSEPH LOPEZ, M.D.

STATE OF TEXAS §
§
DENTON COUNTY §

BEFORE ME, the undersigned authority, on this day personally appeared Joseph Lopez, M.D., who, under oath, stated as follows:

1. "My name is Joseph Lopez. I am over twenty-one (21) years of age, have never been convicted of a felony or other crime involving moral turpitude, and suffer from no mental or physical disability that would render me incompetent to make this Affidavit. I have personal knowledge of each statement set forth herein, and each such statement is true and correct.

2. "I am Juan Davila's primary care physician under Mr. Davila's Aetna PPO healthcare plan. In April of 2000, I prescribed Vioxx to ease the pain and discomfort Mr. Davila was experiencing associated with his arthritis. Compared to other drugs on the AEtna formulary, Vioxx has been shown

in studies to have a lower incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforation of the stomach. Attached hereto as Exhibit '1' are copies of several such studies, and are hereby incorporated by reference. Reducing the likelihood of gastrointestinal toxicity was one of my chief concerns I had with respect to prescribing Vioxx for Mr. Davila.

3. "I was told by Mr. Davila that when he tried to have the prescription filled, AEtna refused to fill the prescription. After I contacted AEtna regarding its refusal, AEtna sent me a letter, a true and correct copy of which is attached hereto as Exhibit '2.'

4. "According to this letter, I would be required to prescribe at least two (2) formulary non-steroidal anti-inflammatory drugs ("NSAIDs"), to which Mr. Davila had a 'contraindication, intolerance, allergy to or a documented adequate trial' before a prescription for Vioxx would be approved. Therefore, the drug I had chosen based on my own experience and medical judgment as best-suited to treat Mr. Davila was rejected in favor of a cheaper, generic drug (naprosyn) which has been shown to have a higher incidence of gastrointestinal toxicity, such as bleeding, ulceration, and perforations of the stomach than Vioxx.

5. "Through AEtna's formulary policies, AEtna influenced and controlled my health care treatment decisions regarding Juan Davila, and directly affected the quality of care and treatment provided to Juan Davila.

6. "After Juan was on naprosyn for several weeks, he began to experience weakness and related symptoms in late June of 2000. At the emergency room, it was discovered that he suffered from bleeding ulcers, which resulted in a near-heart attack, and was within hours of dying from internal bleeding. As a result of these complications, Juan will not be able to take any other pain medication for his arthritis-related

pain which has to be absorbed through the stomach, including aspirin.

7. "I am familiar with the methods of operation and procedures of managed care entities with respect to their determinations of the medical necessity of treatments recommended for their members. I am also familiar with AEtna's formulary policies as set forth above. In Mr. Davila's case, AEtna's formulary policies which required that Mr. Davila be subjected to two (2) different, potentially more dangerous, NSAIDS before being evaluated for Vioxx, despite Vioxx being on the AEtna formulary, fell below the standard of ordinary care for similarly situated managed care entities, and, in ray opinion, resulted in the gastrointestinal injury to Mr. Davila.

"FURTHER AFFIANT SAYETH NOT."

/s/
JOSEPH LOPEZ, M.D.

SWORN TO AND SUBSCRIBED before me by Joseph Lopez, M.D. on this the 19th day of October, 2000, to certify which witness my hand and official seal of office.

[SEAL] /s/
Notary Public in and for
The State of Texas

[Exhibit 1 to Affidavit of Joseph Lopez, M.D. Omitted]

[Exhibit 2 to Affidavit of Joseph Lopez, M.D.]

[Seal]

May 10, 2000

DR LOPEZ
FAX# 940-382-4447

Re: JUAN DAVILA
Member ID: BBCXM3HA

Dear Doctor

As a part of our commitment to provide access to quality care for our members, Aetna U.S. Healthcare conducts a utilization review program with physicians, hospitals, and others who provide care, services and equipment to our members. A request for authorization of coverage of the drug Vioxx has been reviewed. The member's benefit design requires precertification for this drug in the Aetna U.S. Healthcare Medication Formulary Guide ("Formulary"). Precertification for Vioxx will be approved if the member has a diagnosis of osteoarthritis or acute pain and has a contraindication, intolerance, allergy to or a documented adequate trial of at least two (2) formulary NSAIDs. Covered alternative medications in this therapeutic class include ibuprofen, naproxen, Arthrotec, diclofenac sodium, erodoiac, iodomethacin/SR, telmetin, piroxicarn, sulindac, or fenoprofen. Based on the review of information submitted to us, your request to authorize payment for the Formulary excluded medication has been denied.

Aetna U.S. Healthcare makes coverage decisions based on nationally recognized standards of care established by governmental regulatory agencies, scientific evidence in the peer reviewed medical literature, input from physicians recog-

nized to be expert in the area and guidelines established by professional societies.

If the member, or the provider on behalf of the member, wishes to take exception to this decision he/she may file a formal grievance with the HMO. A formal grievance may be filed by calling our Member Services Department using the phone number displayed on the member enrollment card, to request a description of the Aetna U.S. Healthcare Grievance Resolution Procedures, or by submitting a complete, written explanation of his/her grievance, together with a copy of this letter and any supporting documentation, to the U.S. Healthcare Grievance Department, Aetna US Healthcare P.O. Box 150927 Arlington, TX 76015-0927 or refer to the member handbook. An expedited appeal may be requested for life threatening conditions or for a patient already in the hospital.

You have the right to review by an Independent Review Organization (IRO) of adverse coverage determinations based on medical necessity. If the adverse determination involves a life-threatening condition, you have the right to request immediate review by an IRO. Contact Member Services or you may contact the Texas Department of Insurance if you wish to request an IRO.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

By Telephone	In writing
1-800-252-3439	P.O. Box 149184
or Fax to 512-274-1771	Austin, TX 78715

Note: The health plan's time limit for review of your appeal will not begin until your request for appeal is received.

Sincerely,

Nancy Nelson, Pharm D.
Aetna U.S. Healthcare Inc.

APPENDIX I

NO. 067-185326-00

JUAN DAVILA	§	IN THE DISTRICT
	§	COURT
Plaintiff,	§	
	§	
VS.	§	
	§	TARRANT
AETNA U.S. HEALTHCARE	§	COUNTY, TEXAS
INC., and AETNA U.S.	§	
HEALTHCARE OF	§	67TH JUDICIAL
NORTH TEXAS, INC.	§	DISTRICT
	§	
Defendants.	§	

NOTICE OF REMOVAL OF STATE COURT ACTION

TO: Plaintiff Juan Davila, by and through his attorney of record, George Parker Young, Friedman, Young, Suder & Coolie, P. O. Box 2308, Fort Worth, Texas 76113

You are hereby notified that on the 12th day of December, 2000, a Notice of Removal of Civil Action, a true and correct copy of which is attached hereto, was filed in the United States District Court for the Northern District of Texas, Fort Worth Division. The Notice of Removal was filed in reference to Cause No. 067-185326-00: *Juan Davila v. Aetna U.S. Healthcare, Inc, and Aetna U.S. Healthcare of North Texas. Inc.*: then pending in the 67th Judicial District Court of Tarrant County, Texas.

Respectfully submitted,

Andrews & Kurth, L.L.P.

By:_____/s/_____
John B. Shely
State Bar No. 18215300
600 Travis, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200
Facsimile: (713) 220-4285

David Broiles
State Bar No. 03054500
500 Main Street, Suite 1200
Fort Worth, Texas 76102
Telephone: (817) 335-7733
Facsimile: (817) 335-7733

ATTORNEYS FOR AETNA U.S. HEALTHCARE, INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been delivered to the following counsel by certified mail, return receipt requested, no. Z 330 913 329 on the 12th day of December, 2000:

Mr. George Parker Young
Friedman, Young, Suder & Cooke
P.O. Box 2508
Forth Worth, Texas 76113

_____/s/_____
John B. Shely

APPENDIX J

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
v.	§	CIVIL ACTION
	§	NO. _____
AETNA U.S. HEALTHCARE	§	
INC., AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.	§	
	§	
Defendants.	§	

NOTICE OF REMOVAL OF CIVIL ACTION

Defendants Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc., referred to collectively as "Aetna," file this Notice of Removal of the action brought against them by Plaintiff Juan Davila. The grounds in support of this Notice of Removal are as follows:

I.

The Aetna Defendants have been named in a civil action filed on or about November 9, 2000 in the 67th Judicial District Court of Tarrant County, Texas ("State Court Action"). (A true and correct copy of the Plaintiff s Original Petition is attached as Exhibit 1 and incorporated herein for all purposes.)

II.

Aetna U.S. Healthcare, Inc, and Aetna U.S. Healthcare of North Texas, Inc. were both served with or otherwise received a copy of the initial pleading on or about November 14, 2000. (True and correct copies of the citations received by Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. are attached hereto as Exhibit 2 and 3, respectively.) On December 1, 2000, Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. filed their Original Answer in the State Court Action to avoid being in default in the State Court Action. (A true and correct copy of their Original Answer is attached hereto as Exhibit 4).

III.

This Notice of Removal of Civil Action is timely pursuant to 28 U.S.C. § 1446(b) because the State Court Action is being removed within the statutorily allowed thirty day period after the date the first Defendant was served with or otherwise received a copy of the initial pleading and citation.

IV.

Plaintiffs' State Court Action may be removed to this Court because it arises under the laws of the United States. Plaintiff Juan Davila was a participant in an employee benefit plan established and maintained by his employer, Monitronics International Inc., pursuant to the Employee Retirement Income Security Act of 1974, as amended, (ERISA), 29 U.S.C. § 1001 *et seq.* (the "Monitronics Plan"). Aetna U.S. Healthcare of North Texas, Inc. is a health maintenance organization that provides various administrative services to the Monitronics Plan, including making claims determinations as to claims for benefits for medical expenses, including prescription drugs. These claims determination functions include making coverage determinations with respect to whether members' claims for benefits are medically neces-

sary as defined by the terms of the Monitronics Plan. All of Plaintiff s claims arise from Aetna U.S. Healthcare of North Texas, Inc.'s allegedly wrongful denial of benefits for a medication prescribed by Plaintiffs physician, which Plaintiff maintains was covered under the terms of the Monitronics Plan. For example, Plaintiff alleges:

- "Mr. Davila obtained his AEtna PPO health coverage through his employer, Monitronics . . ."[1]
- "Juan's primary care physician[] prescribed Vioxx to ease the pain and discomfort Juan was having. . ."[2]
- "When Juan tried to fill the prescription, however, he was informed that his insurer, AEtna PPO, would not fill it, *even though Vioxx is on the AEtna* formulary."[3]
- "AEetna informed Dr. Lopez that . . . [b]efore Vioxx would be permitted, Juan would have to be placed on two (2) different medications, and suffer a detrimental reaction to these drugs or show no signs of improvement."[4]
- "AEtna's decision to refuse his prescription for Vioxx was final . . ."[5]

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1 Plaintiff's Original Petition, p. 4.

2 Plaintiff's Original Petition, p. 4.

3 Plaintiff's Original Petition, p. 4 (emphasis in original).

4 Plaintiff's Original Petition, p. 4.

5 Plaintiff's Original Petition, p. 4.

- Juan Davila suffered damages "[a]s a result of AEtna's delaying the prescription of Vioxx . . ."[6]

Because Section 502(a) of ERISA provides the exclusive remedies for the wrongful denial of plan benefits as alleged by Plaintiff, Plaintiff's state law claims are completely preempted and removable to this Court. *See Cristantielli v. Kaiser Foundation Health Plan of Texas*, 113 F. Supp. 2d 1055, 1065 (N.D. Tex. 2000) (finding claims that HMO failed to authorize timely and/or proper diagnostic testing and examination fall within Section 502(a) and are completely preempted because the plaintiffs' complaint actually centers around the denial of benefits); *see also McClelland v. Gronwaldt*, 155 F.3d 507, 512 n.15 (5th Cir, 1998) *quoting Anderson v. Electronic Data Systems Corp.*, 11 F.3d 1311, 1315 (5th Cir. 1994) ("'Congress may so completely preempt a particular area that any civil complaint raising the select group of claims is necessarily federal in character' and the case may be removed even if no federal claim is asserted in the complaint and federal preemption, raised as a *defense*, is the only issue of federal law implicated in the case.")

V.

Additionally, Plaintiff's claims are completely preempted even though he attempts to assert negligence claims under the Texas Health Care Liability Act ("THCLA"). *See Cristantielli*, 113 F. Supp. 2d at 1064-65. The allegedly wrongful conduct of denying benefits for Vioxx was a coverage determination made by Aetna U.S. Healthcare of North Texas, Inc. in its role of providing claims administrative services to the Monitronics Plan. Indeed, state law claims based on plan administration, including coverage determinations or utilization review, are preempted by ERISA. *See Corporate*

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6 Plaintiff's Original Petition, p. 5.

Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526, 534 (5th Cir.), *pet. filed*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665) (state efforts to regulate the administrative activities of an HMO—*i.e.*, activities such as "determining eligibility and *coverage*"—are preempted by ERISA and are not encompassed by the THCLA in any event). This is true even when the Plaintiff contends his treating physician recommended treatment that was determined not to be covered under the employee benefit plan. *See Corporate Health*, 220 F.3d 641, 643-44 (denying State's motion for rehearing) (state law claims for allegedly wrongful determinations that treatment is not medically necessary are preempted). Moreover, given their true nature, Plaintiff's claims "for negligence are appropriately recharacterized as claims for benefits and therefore fall within the complete preemption of ERISA." *Cristantielli*, 113 F. Supp. 2d at 1065-66.

VI.

The Affidavit of Joseph Lopez, M.D., attached as Exhibit A to Plaintiff's Petition, further demonstrates that the wrongful acts allegedly committed by Aetna constitute plan administration. Specifically, the Affidavit shows that Plaintiff is complaining about the denial of a request for benefits under the Plan, for which the civil enforcement provisions of ERISA provide the exclusive remedies:

> Aetna refused to fill [Mr. Davila's] prescription. After I contacted Aetna regarding its refusal, Aetna sent me a letter [which read], 'Aetna . . . conducts a utilization review program . . . . A request for authorization of coverage of the drug Vioxx has been reviewed. The member's benefit design requires precertification for this drug in the Aetna U.S. Healthcare Medication Formulary Guide. . . [Y]our request to authorize payment for the [drug] has been denied.' . . . [The] formulary policies . . . resulted in the gastrointestinal injury to Mr. Davila.[7]

Accordingly, this Court has original jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e) and the matter is one that may be removed pursuant to 28 U.S.C. § 1441(a) and (b) and controlling case law. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (holding state court action asserting only state law causes of action relating to alleged failure to pay a claim for benefits under an employee benefit plan constitutes a federal question and is removable to federal court); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324-25 (5th Cir. 1992) (removal allowed and preemption found where day home nursing care was ordered instead of hospitalization as a result of alleged cost-containment utilization review regime); *see also Corporate Health*, 220 F.3d at 644-45 (reaffirming its preemption analysis in Corcoran).

VII.

Promptly after fling this Notice of Removal, written notice thereof will be given to Plaintiffs and a copy of this Notice of Removal will be filed with the District Clerk of Tarrant County, Texas, as provided by law. (A true and correct copy of the Notice being filed with the District Clerk of Tarrant County, Texas is attached as Exhibit 5).

VIII.

For the foregoing reasons, Aetna prays that the State Court Action be removed to the United States District Court for the Northern District of Texas. Dallas Division.

---

[7] Exhibit A to Plaintiff's Original Petition (quoting a letter of May 10, 2000 attached as Exhibit A-2 to the Petition).

Respectfully submitted,

By:_____/s/_____
John B. Shely
Attorney-in-Charge
State Bar No. 18215300
ANDREWS & KURTH L.L.P.
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Facsimile: (817) 335-7733

ATTORNEYS FOR AETNA U.S. HEALTHCARE, INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been delivered to the following counsel by certified mail, return receipt requested, no. Z 330 913 329 on the 12th day of December, 2000:

Mr. George Parker Young
Friedman, Young, Suder & Cooke
P.O. Box 2508
Fort Worth, Texas 76113

_____/s/_____
John B. Shely

APPENDIX K

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

GROUP AGREEMENT

This is a **Group Agreement** between Aetna U.S. Healthcare of North Texas Inc. (hereinafter referred to as "**HMO**") and Monitronics International Inc (hereinafter referred to as "**Contract Holder**").

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the terms, conditions, rights, and privileges as set forth in this **Group Agreement** and the Certificate of Coverage. **Members** covered under this **Group Agreement** are subject to all the conditions and provisions contained herein.

This **Group Agreement** is governed by applicable federal law and the laws of Texas.

If any provision of this **Group Agreement** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect. In consideration of the Premium payments made by or on behalf of the **Contract Holder**, **HMO** shall provide coverage for those services described in the Certificate of Coverage subject to the terms and conditions set forth in this **Group Agreement** and the Certificate of Coverage (herein after referred to as "**Certificate**") which is attached to this **Group Agreement**, and fully incorporated herein by reference. The terms and conditions used in this **Group Agreement** have the same meaning given

those terms in the Certificate unless otherwise specifically defined in this **Group Agreement**.

Group Agreement Effective Date: December 1, 1999
Contract Holder Number: 148028

PREMIUMS

A. **Premiums** for the **Covered Benefits** under this **Group Agreement** are set forth in the Cover Sheet attached hereto, which is fully incorporated herein by reference.

B. The **Premiums** set forth in the Cover Sheet shall be effective for the initial term of this **Group Agreement**. Thereafter, if **HMO** gives a minimum of 30 days prior written notice to the **Contract Holder**, **HMO** may change the **Premiums**:

- upon the renewal date of this **Group Agreement**; or
- upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to **Members**.

Payment of the applicable **Premium** on and after that date shall constitute acceptance of those changes by the contract Holder, individually and on behalf of all **Members** enrolled under this **Group Agreement**.

C. **Premiums** are payable to **HMO** on or in advance of each **Premium** due date at the corporate offices of **HMO** unless otherwise specified by **HMO** in writing. The payment of any **Premium** shall not maintain coverage under this **Group Agreement** in force beyond the date when the next payment becomes due; however, a 31 day grace period, during which time this **Group Agreement** will remain in force, shall be granted for payment of each amount due after the first. The **Contract Holder** shall remain liable for the payment of the **Premium** for the time

coverage was in effect during the grace period and the **Member** shall remain liable for **Copayments** owed. A check is not a payment until it is honored by a bank. **HMO** reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

D. Retroactive adjustments to the **Contract Holder's** billings may be made by **HMO** for the termination of **Members** not posted to previous **Contract Holder** billings. However, the **Contract Holder** may only receive a maximum of 2 month's credit for Member terminations which occurred more than 31 days prior to the date **HMO** was notified of such termination by the **Contract Holder**. Retroactive additions will be made at the discretion of **HMO** based upon eligibility guidelines, as detailed in the **Certificate** and on the Schedule of Benefits, and are subject to the payment of all applicable **Premiums**. As between **HMO** and the **Contract Holder**, the **Contract Holder** shall be responsible for any claims paid by **HMO** with respect to a **Member**, to the extent **HMO** relied on the **Contract Holder's** submitted enrollment to confirm coverage where coverage was not valid.

E. **Premiums** shall be paid in full for **Members** whose coverage is effective on the **Premium** due date or whose coverage terminates on the last day of the **Premium** period.

F. If the **Premiums** are not paid by the **Premium** due date, **HMO** will require the **Contract Holder** to pay interest on the overdue amount at 1 1/2% for each month overdue, commencing on the 31st day after the **Premium** due date.

In the event of non-payment of any amount due, **HMO** shall be entitled to all remedies prodded for in law or in equity.

ENROLLMENT

Enrollment for eligible individuals, as described in the **Certificate**, will be permitted during the **Open Enrollment Period**, or within 31 days from the date the individual and any dependent becomes eligible for coverage. Completed enrollment information must be submitted to the **Contract Holder** for transmittal to **HMO**. Eligible individuals and any eligible dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment**. Coverage shall not become effective until confirmed by **HMO**. The **Open Enrollment Period** shall be consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit representatives of **HMO** to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure.

There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the Schedule of Benefits.

The eligibility of the group, the composition of the group and the eligibility requirements used to determine membership in the group which exist at the effective date of this **Group Agreement** are material to the execution of this **Group Agreement** by **HMO**. The **Contract Holder** shall not during the term of this **Group Agreement** modify the **Open Enrollment Period**, the waiting period as described on the Schedule of Benefits, or any other eligibility requirements as described in the **Certificate** and on the Schedule of Benefits, for the purposes of enrolling the **Contract Holder's** eligible

individuals and dependents under this **Group Agreement**, unless agreed to in writing by **HMO**.

CONTRACT HOLDER TERMINATION

A. This **Group Agreement** map be terminated the **Contract Holder** on any **Premium** due date by giving 60 days' prior written notice.

B. The **Contract Holder** may terminate this **Group Agreement** as of its renewal date, by providing **HMO** written notice of non-renewal not less than 60 days prior to the renewal date.

C. The **Contract Holder** may terminate this **Group Agreement** as of the date any Premium change would become effective, by providing **HMO** with written notice of termination not less than 30 days prior to such effective date.

D. **HMO** may terminate or non-renew the **Group Agreement** if:

1. **HMO** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Group Agreement** within the grace period. **HMO** may terminate this **Group Agreement** as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Group Agreement** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period;

2. the **Contract Holder** has performed an act or practice that constitutes fraud or intentional misrepresentation of a material fact in obtaining coverage under this **Group Agreement**;

3. The **Contract Holder** has failed to comply with a material plan provision relating to any employer

contribution or group participation rules, under applicable state or federal law;

4. **HMO** ceases to offer coverage in the market in accordance with state law;

5. **HMO** ceases to offer coverage of a specific product in the market in accordance with state law;

6. the **Contract Holder** no longer has any enrollee under the plan who lives, resides, or works in the **Service Area**;

7. the **Contract Holder's** membership in the association, through which coverage is obtained, ceases.

E. Upon thirty days written notice to the **HMO**, the **Contract Holder** may terminate this **Group Agreement** in the case of a material change by the **HMO** to any provisions required to be disclosed to the **Contract Holder** or **Members** pursuant to State law.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Group Agreement**.

No change in the eligibility or participation requirements of the **Contract Holder** shall be permitted to affect eligibility or enrollment under this **Group Agreement** unless such change is agreed to by **HMO** and the **Contract Holder**, and is not otherwise contrary to applicable state or federal laws, rules or regulations. Breach of this provision is considered a material breach of this **Group Agreement** and may be the basis for termination by giving 60 days' prior written notice. It is the responsibility of the **Contract Holder** to notify the Subscribers of the termination of the **Group Agreement** in compliance with all applicable laws. However, **HMO** reserves the right to notify **Subscribers** of termination of the

Group Agreement for any reason, including non-payment of **Premium**.

In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

INDEPENDENT CONTRACTOR RELATIONSHIPS

A. Between **Participating Providers** and **HMO**.

The relationship between **HMO** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **HMO** nor is **HMO** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **HMO** makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**.

B. Between the **Contract Holder** and **HMO**.

The relationship between **HMO** and the **Contract Holder** is limited to a contractual relationship between independent contractors. Neither party is an agent nor employee of the other in performing its obligations pursuant to this **Group Agreement**.

ADMINISTRATION OF THE AGREEMENT

HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Group Agreement**.

A. Entire Agreement.

This **Group Agreement**, including the Group Application, Cover Sheet, Certificate of Coverage, Schedule of Benefits, any Riders, and any amendments, endorsements, inserts or attachments, constitutes the entire **Group Agreement** between the **Contract Holder** and **HMO**, and on the **Effective Date of Coverage**, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by **HMO** for **Covered Benefits** provided by this **Group Agreement**.

All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **HMO** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

B. Amendments.

This **Group Agreement** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **HMO**, and this **Group Agreement** shall be deemed to be amended to conform therewith at all times. This **Group Agreement** may be changed at any time for any other reason by agreement between **HMO** and the **Contract Holder**, without the consent of any employee, **Member**, or other person. Except as detailed below, any amendments to this **Group Agreement** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **HMO**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **HMO** by making any other

commitment or representation or by giving or receiving any information. No change in this **Group Agreement** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **HMO**.

Formal acceptance of an amendment to this **Group Agreement** by the **Contract Holder** shall not be required if:

1. the change was requested by either the **Contract Holder** or **HMO** and is agreed to in writing by the other; or
2. the change is required to bring the **Group Agreement** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Group Agreement** is delivered; or
3. the **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.

C. Forms.

HMO shall supply the **Contract Holder** with a reasonable supply of its forms and descriptive literature. The **Contract Holder** shall distribute **HMO's** forms and descriptive literature to any eligible individual who becomes eligible for coverage. The **Contract Holder** shall, within 20 business days of receipt from an eligible individual, forward all applicable forms and other required information to **HMO**.

D. Records.

HMO shall maintain **Member** records. The records will contain key facts about the **Member's** coverage. Each month during the period of this **Group Agreement**, on forms approved by **HMO**, the **Contract Holder** shall furnish to **HMO** such information as may

reasonably be required to administer the **Group Agreement**. This includes, but is not limited to, information needed to enroll **Members** of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**. **HMO** shall not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **HMO**.

The **Contract Holder** shall make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **HMO** for inspection, at **HMO's** expense, at the **Contract Holder's** office, during regular business hours, upon reasonable advance request from **HMO**. This provision shall survive the termination of this **Group Agreement** as necessary to resolve outstanding financial or administrative issues pursuant to this **Group Agreement**.

E. Clerical Errors.

Incorrect information furnished to **HMO** may be corrected, provided that **HMO** has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if **HMO**, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to **Members**. Upon discovery of such errors or delay, an adjustment of **Premiums** shall be made. In no case will adjustments in coverage or **Premiums** be made effective more than 2 **Premium** due dates prior to the date **HMO** is notified in writing, on a form satisfactory to **HMO**, of the requested addition, deletion, or change in coverage.

F. Claim Determinations.

HMO has complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **HMO** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this **Group Agreement**. **HMO** shall be deemed to have properly exercised such authority unless **HMO** abuses its discretion by acting arbitrarily and capriciously.

G. Fraudulent or Intentional Misrepresentations.

If any relevant fact as to a **Member** is found to have been misrepresentation, an equitable adjustment of **Premiums** may be made. If the misrepresentation affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force.

H. Incontestability.

Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

1. No statement made by the **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
2. No statement made by the **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for 2 years from its effective date.
3. No statement made by a **Member** shall be used in defense of a claim for loss incurred or commencing after coverage has been in effect for 2 years.

I. Assignability.

No rights or benefits under this **Group Agreement** are assignable by the **Contract Holder** to any other party unless approved by **HMO**.

J. Waiver.

HMO's failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **HMO's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

K. Notices.

Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or Cover Sheet, or to any more recent address of which the sending party has received written notice.

L. Third Parties.

This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

M. Non-Discrimination.

The **Contract Holder** agrees to offer participation in **HMO** to all persons as described in the Subscriber Eligibility section of the Schedule of Benefits under terms and conditions no less favorable than those for any alternate health benefit plans. The **Contract Holder** agrees

to make no attempt, whether through differential **Contract Holder Premium** contributions or otherwise to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

N. Execution of this Agreement.

This **Group Agreement** shall be executed by **HMO** and the **Contract Holder** once the Group Application, which is attached hereto and fully incorporated herein by reference, is completed and signed. However, payment of the applicable Premium on and after the effective date of this **Group Agreement** shall constitute execution of this **Group Agreement** by the **Contract Holder**.

O. Inability to Arrange Services.

In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **HMO's Participating Providers** or entities with whom **HMO** has arranged for services under this **Group Agreement**, or similar causes, the rendition of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

P. Use of the HMO Name and all Symbols, Trademarks, and Service Marks.

HMO reserves the right to control the use of its name and all symbols, trademarks, and service marks presently

existing or hereinafter established with respect to it. The **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without prior written consent of **HMO** and will cease any and all usage immediately upon request of HMO or upon termination of this **Group Agreement**.

Q. Worker's Compensation.

The **Contract Holder** is responsible for protecting **HMO's** interests in any workers compensation claims or settlements with any eligible individual. **HMO** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

At the signing of this **Group Agreement** and upon renewal, the **Contract Holder** shall submit proof of their worker's compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Worker's Compensation. The **Contract Holder** is also required to submit a monthly report to **HMO** listing all worker's compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individual.

R. Conflict Between **Group Agreement** and **Certificate**

Any direct conflict between the **Group Agreement** and the **Certificate** will be resolved according to the terms which are most favorable to the **Subscriber**.

APPENDIX L

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)
2777 Stemmons Freeway, Suite 400
Dallas, Texas 75207
214-200-8000 or 1-800-992-7947

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna U.S. Healthcare of North Texas Inc., hereinafter referred to as HMO, and the Contract Holder. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **Certificate** or added thereafter.

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

The Group Agreement under which this Certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system. This Certificate is governed by applicable federal law and the laws of Texas.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31 DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THE GROUP AGREEMENT AND THE CERTIFICATE OF COVERAGE CONTAIN NO ARBITRATION PROVISION.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact HMO's Member Service Department at 1-800-992-7947.

You may call HMO's toll-free telephone number for information or to make a complaint at 1-800-992-7947

You may also write to HMO at:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact HMO first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener information o para someter una queja:

Puede comunicarse con su HMO Member Service Department al 1-800-992-7947.

Usted puede llamar al numero de telefono gratis de (company)'s para information o para someter una queja al 1-800-992-7947

Usted tambien puede escribir a HMO:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTES SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el HMO primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER:

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-228-1570.

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS:

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-228-1570.

Su queja sera referida a la agencia estatal que regula el hospital o centro de tratamiento para la dependencia quimica.

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HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access Covered Benefits as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf if a **Member** does not select a **PCP** at the time of enrollment, the **HMO** will assign a **PCP** to the **Member**. The **Member** retains the right to reject the **PCP** assigned the **Member** however the **Member** must select another **PCP** at the time of rejection. The **HMO** will, in good faith, assign a **PCP** located near to a **Member's** residence or place of employment.

A **Member** who has been diagnosed with a chronic, disabling or life threatening illness may apply to the **HMO's** Medical Director to be able to select a **Participating Specialist** as the **Member's PCP**. The **HMO** will specify to the **Member** the information necessary, including certification of the medical need, and signatures of the **Member** and the **Participating Specialist** interested in serving as the **Member's PCP**. The **Participating Specialist** must meet the **HMO's** requirements for **PCP** participation and be willing to accept the coordination of all the **Member's** healthcare needs. The designation of the **Participating Specialist** as the **Member's PCP** will not be retroactive. If the request for special consideration of a **Participating Specialist** is denied, a **Member** may appeal the decision through the **HMO's** established Grievance/Complaint Procedure.

B. **The Primary Care Physician.**

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the **Covered Benefits** section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

Should **Medically Necessary** covered services be unavailable through a **Participating Provider**, upon the request of the **Primary Care Physician** or **Participating Provider** and with prior approval of the **HMO**, a **Referral** may be made to a non-**Participating Provider** for those **Medically Necessary** covered services.

The **HMO** will allow for a review by a **Specialist** of the same or similar specialty as the type of **Physician** or **Provider** to whom the **Referral** was requested prior to the **HMO's** approval of the **Referral**.

C. **Availability of Providers.**

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Pro-**

vider contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**.

D. **Changing a PCP.**

A **Member** may change the **PCP** at any time by calling the **Member** Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request. The **Member** may change their **PCP** up to four times in a twelve month period.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination.

F. **Provider Communication.**

HMO will not prohibit, attempt to prohibit or discourage any **Health Professional** from discussing or communicating to a **Member** or a **Member's** designee any information or opinions regarding the **Member's** health care, any provisions of health care plan as it relates to the medical needs of the **Member** or the fact

that the **Health Professional's** contract with the **HMO** has terminated or will no longer be providing services under the **HMO**.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:

   a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

   b. live or work in the **Service Area**.

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

   a. the spouse of a **Subscriber** under this **Certificate**; or

   b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, and dependents of dependents) who meets the eligibility requirements described on the Schedule of Benefits.

B. **Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services. Submission of complete enrollment information and **Premium** payment to **HMO** must be made within 31 days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

   An eligible individual and any eligible dependents who are eligible may enroll.

2. Open Enrollment Period

   Eligible individuals or any dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. Enrollment of Newly Eligible Dependents.

   a. Newborn Children.

      A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, notification of the birth and any required additional **Premium** must be received by **HMO** not later than the 31st day after the date of birth. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

      The coverage for newly born; adopted children and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

   b. Adopted Children.

      A legally adopted child, a child for whom a **Subscriber** is a court appointed legal guardian, or a child for which the **Subscriber** is a party in a suit in which the adoption of the child by the

Subscriber is sought, and who meets the definition of a **Covered Dependent**, will be treated as a dependent. The **Subscriber** must make a written request for coverage within 31 days of the date the adoption is final or the legal guardianship has been decreed, or within 31 days after the **Subscriber** is a party in a suit for adoption.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective. The coverage shall be comparable to the coverage provided to other **Covered Dependents**. The child must meet the definition of a **Covered Dependent**, and the **Subscriber** must make a written request for coverage within 31 days of the court order.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility as defined on the Schedule of Benefits; Dependent Eligibility In order to continue coverage for a handicapped child, the **Subscriber** must provide proof of the child's incapacity and dependency to **HMO** within 31 days of the date the child attains the limiting age. Subsequent proof may be requested by the **HMO**, not more frequently than annually, and must be provided by the **Subscriber** in order to continue such coverage. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to

HMO that a dependent meets the eligibility requirements described in this **Certificate**.

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. The eligible individual or the eligible dependent will not be subject to the late enrollment provision described below. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

a. an eligible individual or an eligible dependent's covered under another group health plan or self-funded employer health benefit plan when initially eligible for coverage under **HMO**;

b. the eligible individual or eligible dependent declines coverage in writing under **HMO** during the initial eligibility stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or self-funded employer health benefit plan for one of the following reasons:

   i. termination of employment; or
   ii. reduction in the number of hours of employment; or

   iii. termination of contributions toward the premium made by the employer, or
   iv. death of a spouse or divorce; or

   Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the **HMO Certificate**; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

   The effective date of coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

   The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to any late enrollment or pre-existing condition provision described in this **Certificate**.

C. **Effective Date of Coverage.**

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement**.

Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a

Covered Benefit under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physi-**

cian's office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient Hospital Services; and

- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **HMO's** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member's** health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO's** attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member services 800 telephone number listed on the **Member's** identification card

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.

2. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

   a. call the **PCP's** office; and

   b. identify himself or herself as a **Member;** and

   c. follow the **PCP's** or covering **Physician's** instructions.

   If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care Benefits section of this **Certificate**.

3. Hospital visits.

4. Periodic health evaluations to include:

   a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations, including but not limited to immunization against diphtheria; haemophilus; influenza type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella, which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services or as required by law.

   b. routine physical examinations.

   c. routine gynecological examinations, including pap smears, for routine care, administered by the **PCP**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.

   d. routine speech and hearing screenings.

   e. immunizations (but not if solely for the purpose of travel or employment).

   f. routine vision screenings.

5. Injections, including allergy desensitization injections.

6. Casts and dressings.

7. Health Education Counseling and Information.

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.

2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gynecologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- age 35 and older, one routine mammography every year; or
- when **Medically Necessary**.

3. prostate cancer screening, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from his **PCP**, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit

Prostate Cancer Screening benefits for male **Members** are provided as follows:

- age 40-49, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year, if the **Member** is at an increased risk of developing prostate cancer as determined by his physician; or
- age 50 and older, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits.

- Open Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. Open access includes care related to pregnancy; care for-all active gynecological conditions; and diagnosis, treatment and referral for any disease or condition which is within the scope of the professional OB/GYN practice. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.
- Routine Eye Examinations, including refraction, as follows:

1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

E. **Maternity Care and Related Newborn Care.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers**.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area**

unless the **Member** receives prior authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at participating **Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is prodded for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

   If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for timely post-delivery care. Post-delivery care may be provided to the mother and child by a **Physician**, registered nurse, or

other appropriate licensed health care **Provider** and may be provided at the mother's home, a health care **Provider's** office, or a health care facility. Benefits include postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care. A **Copayment** will not apply for home health care visits.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided for a **Member** following a mastectomy:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a mastectomy;
2. a minimum of 24 hours of inpatient care in a **Participating Hospital** following a lymph node dissection for the treatment of breast cancer.

A **Member** may request a shorter length of stay if the **Member's Participating Provider** determines the shorter stay to be appropriate.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. **Transplants.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically ap-

proved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to preauthorization by **HMO**.

I. **Chemical Dependency Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification** and treatment of **Chemical Dependency**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or a controlled substance.

2. Inpatient care benefits in a **Participating Hospital** or treatment facility that is a **Participating Provider** are covered for the medical complications and treatment of **Chemical Dependency** and **Detoxification**. Benefits include medical treatment and referral services for **Chemical Dependency** or addiction. The following services shall be covered under inpatient

treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray, psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

J. **Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** through **Participating Behavioral Health Providers**.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

2. Benefits for **Serious Mental Illness**

Inpatient care received in a participating **Hospital** or **Participating Mental Health Treatment Facility** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** while the **Member** is a full-time inpatient is covered. Coverage is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

Outpatient care received from a **Participating Provider** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** is covered. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits. Any outpatient visits for the purpose of medication management will not be counted toward the maximum number of visits, and visits for medication management will be under the same terms and conditions as for outpatient visits for treatment of physical illness generally.

Coverage for **Serious Mental Illness** will include the same **Copayments** as for any other physical illness.

K. **Emergency Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**.

   Benefits include:

   a. a medical screening examination/evaluation, in accordance with any State or Federal law, the purpose of which is to determine whether an emergency medical condition exists;

   b. the treatment and stabilization of the **Member** for the emergency medical condition;

   c. services originating in a **Hospital** emergency facility or comparable facility following treatment or stabilization of an emergency medical condition, as approved by **HMO**. In addition, the **HMO** reserves the right to approved or deny coverage of any post-stabilization care as requested by a **Provider**, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the **Member**, but in no case to exceed one hour from the time of the request

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-**Participating Provider** located either within or outside the **HMO Service Area**, for those expenses,

less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**.

2. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received

L. **Rehabilitation Benefits.**

A **Member** is covered for rehabilitation, services, and therapies benefits that, in the opinion of a **Participating Physician**, are **Medically Necessary** if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

M. **Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency. Preauthorization must be obtained from the **Member's** attending **Participating Physician**. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.
3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.
4. Physical, speech and hearing, or occupational therapy is covered.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when preauthorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or

legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house are not covered. Coverage is not provided for **Respite Care**.

O. **Prosthetic Appliances.**

The **Member's** initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects are covered, when such devices are prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

P. **Injectable Medications.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe

federal legend prescription drugs or medicines, and approved in advance of treatment by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an **HMO Participating** pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. **Infertility Services.**

Infertility services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

R. **Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when preauthorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ.

S. **Diabetes Related Benefits.**

Benefits for the treatment of diabetes and associated conditions. Coverage includes diabetes equipment, diabetes supplies and diabetes self-management training. All provisions applicable to other illness and surgical treatment, including **Copayments**, will apply to benefits for diabetes related coverage.

T. **Additional Benefits.**

Durable Medical Equipment Benefits. Durable Medical Equipment will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by a rider attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary** Services. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy.

- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibulopiasty treatment of periodontal disease, and dental implants are not covered. This exclusion does not include bone fractures, removal of tumors, and orthodontogenic cysts. Dental services and supplies for treatment of temporomandibular joint (TMJ) dysfunction except for diagnostic and medical/surgical treatment of TMJ.
- **Durable Medical Equipment**, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances,

improvements made to a **Member's** house or place of business, and adjustments made to vehicles.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- **Experimental** or **Investigational Procedure**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or Investigational health care procedures or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered

  This exclusion will not apply with respect to drugs:

  1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- False teeth.
- Hair analysis.

- Health services, specifically charges for health services, incurred before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**. This does not include covered services resulting from complications of pregnancy incurred after the **Member's** effective date.
- Hearing aids.
- Household equipment, including but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
- Household fixtures, including but not limited to, the purchase or rental of escalators, elevators, and swimming pools.
- Hypnotherapy, except when specifically approved by **HMO**.
- Implantable drugs.
- **Infertility** services, including the treatment of male and female **Infertility**, injectable **Infertility** drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg program or gestational carriers. This exclusion does not apply to artificial insemination, **Medically Necessary** services to diagnose and treat the underlying medical cause of **Infertility**, or donor sperm.
- Inpatient care for **Serious Mental Illness** which is not provided in a **Hospital** or **Mental Health Treatment Facility**; non-medical ancillary services and long-term rehabilitation services for **Serious Mental Illness**.

- Inpatient treatment for **Mental or Behavioral Conditions** unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.
- Non-medically necessary services, including but not limited to, those services and supplies:
  1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  2. that do not require the technical skills of a medical, mental health or a dental professional;
  3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
  5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.

- Outpatient prescription or non-prescription drugs and medicines unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips, except that this exclusion does not apply to diabetes supplies.
- Payment for benefits for which Medicare or a third party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Private duty or special nursing care, unless preauthorized by **HMO**.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship, counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.

- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be trade.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  2. needles, syringes and other injectable aids, except that this exclusion does not apply to diabetes supplies;

  3. drugs related to the treatment of non-covered services; and
  4. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex. regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to **HMO** that the **Member** is covered under a workers' compensation law or similar law, but

is not covered for a particular disease or injury under such law. that disease or injury will be considered "non-occupational" regardless of cause.

- Treatment of spinal disorder services, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency** or when it is a direct access benefit.
- Vision care services and supplies.
- Weight reduction programs, or dietary supplements.
- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Services related to the care, filling, removal or replacement of impacted teeth.

B. **Limitations.**

In the event there are two or more alternative Medical Services which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly Medical Service, as determined by **HMO**, provided that **HMO** approves coverage for the Medical Service or treatment in advance.

Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of

this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA, however may be eligible for continuation of coverage as provided by subsection B of this section. Continuation of Coverage—State of Texas.

1. Minimum Size of Group:

   The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

   a. divorce or legal separation, or

   b. **Subscriber's** death, or

   c. **Subscriber's** entitlement to Medicare benefits, or,

   d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

   The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

   a. the last day of the 18-month period.

   b. the last day of the 36-month period.

   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

   d. the first day on which the **Contract Holder** ceases to maintain any group health plan.

   e. the first day on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

   f. the date the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

   a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.

   b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Member's** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

6 Responsibility to provide **Member** with notice of Continuation Rights:

   The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay **Premiums** to **HMO**:

   Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days of submitting the application to the **Contract**

Holder and **Contract Holder** in turn remitting same to **HMO**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. **Continuation of Coverage—State of Texas.**

1. Continuation Privilege for Certain Dependents.

A **Covered Dependent** who has been a **Member** of the **HMO** for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Certificate** if coverage would otherwise terminate because of:

a. the death of the **Subscriber**,

b. the retirement of the **Subscriber**, or

c. divorce or legal separation.

A **Member** must give written notice to **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable **Premiums** and administrative charges are paid

Continuation of coverage under this section will terminate on the earliest to occur of:

a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;

b. the end of the 3 year period after the date of the divorce or legal separation;

c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or

d. the end of the period for which the **Member** has paid any applicable **Premiums**.

2. Group Continuation Privilege.

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the **Certificate** or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 31 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** written election of continuation, together with the first contribution required to establish **Premiums** on a monthly basis in advance, must be given to the **Contract Holder**

within 31 days of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**.

Continuation of coverage under this section will terminate on the earliest to occur of:

a. six months after the date the election is made;

b. the date on which failure to make timely payments would terminate coverage;

c. the date on which the group coverage terminates in its entirety;

d. the date on which the **Member** is or could be covered under Medicare;

e. the date on which the **Member** is covered for similar benefits by another **Hospital**, surgical, medical, or major medical expense insurance policy or **Hospital** or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program;

f. the date the **Member** is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

g. similar benefits are provided or available to the **Member**, pursuant to or in accordance with the requirements of any state or federal law.

C. **Conversion Privilege.**

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege in accordance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA or state law, benefits as described in the COBRA Continuation Coverage or Continuation of Coverage—State of Texas sections of this **Certificate**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **Certificate** and has been continuously enrolled for 3 months under **HMO**, such person may, within 31 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of good health provided that **Member's** coverage under this **Certificate** terminated for one of the following reasons:

a. Coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder;** or

b. The **Subscriber** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate**, in which case the **Subscriber** and **Subscriber's** depend-

ents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert; or

c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age; or

d. Continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without punishing evidence of good health. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

D. **Extension of Benefits While Member is Receiving Inpatient Care.**

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay; or
2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached; or
4. the date the **Member** becomes covered for similar coverage from another health benefits plan; or
5. 12 months from the termination date of the **Group Agreement**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

GRIEVANCE/COMPLAINT PROCEDURE

In situations when **Members** are dissatisfied with **HMO** services, the following procedures govern complaints, grievances, and grievance/complaint appeals made or submitted by **Members**. These complaints, grievances and grievance/ complaint appeals will be handled in a timely manner.

A. **Definitions.**

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancella-

tions, terminations or renewals, and the quality of services provided. **HMO** encourages **Members** to resolve an individual inquiry without the initiation of a Grievance/Complaint Review.

2. A "grievance/complaint" is any dissatisfaction expressed by a **Member** orally or in writing to **HMO** with any aspect of **HMO's** operation, including but not limited to:

   a. dissatisfaction with plan administration;

   b. appeal of an adverse determination;

   c. the denial, reduction, or termination of a service;

   d. the way a service is provided; or

   e. disenrollment decisions.

   A grievance/complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the **Member**.

B. **Grievance/Complaint Review.**

   1. **HMO** will send the **Member** acknowledgment of the grievance/complaint within 5 business days of having received it. The acknowledgment will contain:

      i. the date of receipt of the grievance/complaint;

      ii. a description of **HMO's** grievance/complaint procedures and time frames;

      iii. a one-page complaint form, clearly stating that the grievance/complaint form must be returned to **HMO** for prompt resolution of the grievance/complaint, if the grievance/complaint is received orally;

      iv. requests for the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance/complaint; and

      iii. a notice informing the **Member** of the **Member's** right to have an uninvolved **HMO** representative assist the **Member** in understanding the grievance/complaint process.

   HMO will acknowledge, investigate, and resolve the grievance/complaint within 30 calendar days from the date of receipt of the written grievance or one-page grievance/complaint form.

   2. The Grievance/Complaint Panel deciding the grievance/complaint shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance/complaint.

   3. A written notice stating the result of the review by the Grievance/Complaint Panel shall be forwarded by **HMO** to the **Member**. Such notice shall include:

      a. a description of the Panel's understanding of the **Member's** grievance/complaint as presented to the Grievance/Complaint Panel (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and

      b. the Panel's decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical

report, the services were not covered by the **Certificate**, etc.); and

c. citations to the evidence or documentation used as the basis for the decision, including the specialization of any **Provider** consulted (i.e., reference to the **Certificate**, medical records, etc.);

d. if the decision is to deny services based on an adverse determination of **Medical Necessity**, the clinical bases used to reach that decision;

e. that the decision of the Grievance/Complaint Panel shall be final and binding unless appealed by the **Member** to **HMO** within sixty (60) days of the date of the notice of the decision of the Grievance/Complaint Panel; and

f. a full description of the appeals process and the time frames for the final decision on the appeal.

C. **Appeal Hearing.**

1. Upon receipt of a written appeal by the Appeal Panel, **HMO** shall provide the **Member** filing the appeal with an acknowledgment letter within 5 business days. This letter shall contain the procedures governing appeals before the Appeal Panel including the date and location for the **Member** to appear before the Appeal Panel. The appeal process gives the **Member** the opportunity to appear in person before the Appeal Panel or address the **Member's** issues through a written appeal to the Appeal Panel. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

   No less than 5 business days prior to the **Member's** appearing before the Appeal Panel, the **Member**

will receive a copy of any documentation to be presented by the **HMO** staff; the specialization of **Physicians** or **Providers** consulted during the review, and the name and affiliation of all **HMO** representatives on the Appeal Panel. The **Member** may respond to this information for the Appeal Panel to consider in the **HMO's** deliberations.

2. The Appeal Panel shall be established by the Board of Directors of the **HMO** and shall be comprised of equal numbers of non-employee **HMO Members**; **HMO** staff persons not previously involved in the disputed decision; and **Physicians** or **Providers** experienced in the area of care that is in dispute and who are independent of the **Physicians** or **Providers** who made the prior decision that resulted in the **Member's** appeal. If specialty care is in dispute, the appeal panel must include an additional person who is a **Specialist** in the field of care to which the appeal relates.

3. The Appeal Panel shall hold appeal hearings within the **Members** county of residence or the county where the **Member** normally receives the **HMO's** health care services. Another location may be used if in agreement by the **Member** and **HMO**.

4. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, including any person responsible for making the prior determination that resulted in the appeal, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their grievance. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to pre-

sent witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Grievance/Complaint Appeal Panel shall have the right to question the **HMO** representative, the **Member** and any other witnesses.

5. The appeal hearing shall be informal. The Appeal Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Panel shall have the right to exclude redundant testimony or excessive argument by any party or witness.

6. A written record of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Appeal Panel shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Panel. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Appeal Panel shall be confidential and shall not be transcribed.

8. The Appeal Panel shall render a written decision within 30 days of the conclusion of the appeal hearing. The decision shall contain:

   a. date of receipt of the oral or written request for appeal;

   b. a statement of the Appeal Panel's understanding of the nature of the grievance/complaint and the material facts related thereto;

   c. the Appeal Panel's decision and rationale, including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision;

   d. a summary of the evidence, including necessary document supporting the decision; and

   e. a statement of the **Member's** right to appeal to the Department of Insurance, with the following toll-free telephone number and complete address of the Department of Insurance:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714 – 9104
1 - 800 - 252 - 3439.

D. **Ongoing Emergency or Denial of Continued Stays for Hospitalization Appeals.**

Investigation and resolution of appeals related to ongoing emergencies or denials of continued stays for hospitalization grievances will be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed 1 business day from the **Member's** request for appeal.

Due to the ongoing emergency or continued hospital stay, and at the **Member's** request, **HMO** shall provide, in lieu of a grievance/complaint appeal panel, a review by a **Provider** not previously involved with the prior decision and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal. The **Provider** reviewing the appeal may interview the **Member** or the **Member's** designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within 3 days.

E **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a complaint by the Department of Insurance or
2. the filing of a complaint with the Department of Insurance; or
3. the establishing of any litigation or any administrative proceeding regarding either any alleged breach of the **Group Agreement** or **Certificate** by **HMO**, or any matter within the scope of the grievance/ complaint resolution process of any complaint, grievance or grievance appeal.

F. **Record Retention.**

HMO shall retain the records of all grievances/complaints for a period of at least 7 years from the date of the receipt of the grievance/complaint. The records will include each grievance/complaint and any grievance/complaint proceeding and any actions taken on a grievance/complaint. A **Member** is entitled to a copy of the record on the applicable grievance/complaint and any grievance/complaint proceeding.

G. **Independent Review Organization (IRO).**

A **Member** whose appeal of an adverse determination is denied by **HMO** has the right to seek review of that determination by an IRO assigned to the appeal in accordance with state law. Not later than the third business day after the date that **HMO** receives a request for review, **HMO** will provide to the IRO the following:

1. any medical records of the **Member** that are relevant to the review;

2. any documents used by **HMO** in making the determination;
3. the written notification of the Appeal Hearing decision provided to the **Member;**
4. any documentation and written information submitted to **HMO** in support of the appeal; and
5. a list of each **Provider** who has provided care to the **Member** and who may have medical records relevant to the appeal.

HMO will comply with the IRO's determination with respect to the **Medical Necessity** or appropriateness of health care items and services for a **Member**, and pay for the independent review.

In a circumstance involving a **Member's** life-threatening condition, the **Member** is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of **HMO's** adverse determination. A life-threatening condition is a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

H. **Fees and Costs.**

Nothing herein shall be construed to required **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a grievance/complaint or appeal.

I. **HMO** may not refuse to renew or cancel coverage of the **Contract Holder** or a **Member** or take any other retaliatory action because the **Contract Holder** or a **Member** has filed a grievance/complaint or appealed a decision made by **HMO**. Also, **HMO** may not refuse to renew or terminate a contract with a **Participating Provider** or **Participating Physician** in retaliation for the fil-

ing of a grievance/complaint or appeal of a decision made by **HMO**, on behalf of the **Contract Holder** or a **Member**.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate**.

When coverage under this **Certificate** and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the fast rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

B. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   1. secondary to the plan covering the person as a dependent; and

   2. primary to the plan coveting the person as other than a dependent;

the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   1. covers the person as other than a dependent; and

   2. is secondary to Medicare.

C. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:

   1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.

   2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

   3. If there is not such a court decree:

      If the parent with custody of the child has not remarried, the benefits of a plan which covers

the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

E. If A, B, C and D above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or
2. the dependent of such person,

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or
2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision as permitted by State or Federal law.

Other plan means any other plan of health expense coverage under:

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. No-fault and traditional "fault" auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, **HMO** will pay its regular benefits in full, or a reduced benefit. The

reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **Certificate** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an Allowable Expense unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **Certificate**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that

excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

Medicare And Other Federal Or State Government Programs.

The provisions of this section will apply to the maximum extent permitted by federal or state law. **HMO** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that **HMO** determines its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **Certificate** shall be payable to and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

Medicare benefits will be taken into account for any **Member** who is eligible for Medicare. This will be done whether or not the **Member** is enrolled in Medicare.

Active Employees and Their Dependents Who Are Eligible For Medicare.

Certain rules apply to active employees and their **Dependents** who are eligible for Medicare. When a active **Sub-**

scriber, or the **Dependent** of a active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent** belongs to a group covered by this **Certificate** with twenty (20) or more employees, that **Member** must make a written election to the **Contract Holder** indicating whom that **Member** wants to be his primary carrier. If the **Member** elects the **Contract Holder's** group plan as the primary plan, this **Certificate** will be the primary payer. If the **Member** elects Medicare as the primary plan, all benefits otherwise payable to that **Member** under this **Certificate** shall terminate. If the **Member** belongs to a covered group of less than twenty (20) employees, this **Certificate** will be secondary payer and all benefits otherwise payable with respect to the **Member** will be paid in accordance with the Provision for Coordination with Medicare section below.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **Certificate** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Retired Employees and Their Dependents Who Are Eligible For Medicare.

If the eligible class of employees of this **Certificate** includes coverage for retired employees who are eligible for Medicare, the benefits provided by this **Certificate** will be paid in accordance with the Provision for Coordination with Medicare section below.

Provision for Coordination with Medicare.

Benefits under this **Certificate** will cease for any **Member** eligible for Medicare. If coverage would cease because a **Subscriber** is, or could be, eligible for Medicare or any other Federal or State government programs (such as Worker's

Compensation) any benefits in force for the **Subscriber's Covered Dependents** may be continued. Coverage will then continue until it terminates for some other reason under the rules of this **Certificate**. A conversion privilege may be available in the event that a **Dependent's** coverage under this **Certificate** ends because the **Subscriber** becomes eligible for Medicare. This does not apply if the **Member** is eligible for any Medicare related benefits under this **Certificate**.

SUBROGATION

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment of the full cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which the third party is or may be responsible. **HMO** receives all rights of recovery acquired by a **Member** against any person or organization for negligence or any willful act resulting in illness or injury covered by the **HMO Covered Benefits**, but only to the extent of these **Covered Benefits**. Upon receiving such **Covered Benefits** from the **HMO**, the **Member** has considered to have assigned such rights of recovery to the **HMO** and to have agreed to give the **HMO** any reasonable help required to secure the recovery. The recovery may include attorney fees and court costs if applicable.

RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.

C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive

pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**.

B. **Reports and Records. HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the **Member's** records by **HMO**.

C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating**

Provider. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**.

No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any

Participating Provider or other **Provider**, institution, facility or agency.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all Medical Services which are rendered by **Participating Physicians**.

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

   a within thirty days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

   b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the **Provider** Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities

who have contracted with **HMO** to provide services.

G. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.

I. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the **Covered Benefits** section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from

any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

J. **Incontestability.** In the absence of fraud, all statements made by **Subscriber** are considered representations and not warranties. During the first two years, coverage can be voided for material misrepresentation contained in a written application. After two years, coverage can be voided only in the event of a fraudulent misstatement contained in the written application. A copy of the written application must have been furnished to the **Subscriber** if the terms of the application or enrollment forms are to be applied.

K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any

information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

O. This **Certificate**, including the Schedule of Benefits, any Riders, and any amendments, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

P. If this **Certificate** contains any provision not in conformity with Texas state law or other applicable laws it shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Actively at Work.** The condition where an employee is performing all of the **Subscriber's** regular duties for the **Contract Holder** (the **Subscriber's** employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be actively at work on a non-scheduled work day only if such person is actively at work on the last regularly scheduled work

day immediately preceding such non-scheduled work day.

- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.
- **Behavioral Health Provider**. A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Certificate**. This **Certificate** of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Chemical Dependency**. The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.
- **Chemical Dependency Rehabilitation.** Services, procedures and interventions to eliminate the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance, according to individualized treatment plans.
- **Contract Holder**. An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment**. A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.
- **Copayment** Maximum. The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery**. Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty

and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

- **Covered Dependent**. Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Creditable Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.
- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has

reached the maximum level of physical or mental function and such person is not likely to make further significant improvement **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.

- **Detoxification**. The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment**. Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures**. Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
2. required FDA approval has not been granted for marketing; or
3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or

6. it is not ger rally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or

7. it is provided or performed in special settings for research purposes.

- **Group Agreement**. The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professionals**. A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or **Certificate**.

- **HMO**. Aetna U.S. Healthcare of North Texas Inc., a Texas corporation licensed by the Texas Department of Insurance as a Health Maintenance Organization.

- **Homebound Member**. A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services**. Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.

- **Hospice Care**. A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.

- **Hospital**. An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

- **Infertile or Infertility**. The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.

- **Medical Emergency**. The recent onset of a medical condition of severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

  1. placing the patient's health in serious jeopardy,

  2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Some examples of **Medical Emergencies** include heart attacks, convulsions, serious burns, poisoning, loss of consciousness, injuries involving treatment to the mouth and teeth, and conditions that have progressed from a non-emergent situation initially to that of an emergent nature over a period of time, of a few days to as long as a week.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the **Covered Benefits** section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate**.
- **Member**. A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

- **Mental Health Treatment Facility:** A facility that: a) meets licensing standards; b) mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medical services that may be required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.
- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Open Enrollment Period**. A period of not less than 31 days, per calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**. Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month, except that if the

month is February, the period shall last through March 2.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating**. A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician**. A duly licensed **Member** of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or **Certificate**.
- **Premium**. The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician**. A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider**. A **Physician, Health Professional, Hospital, Skilled Nursing Facility,** home health agency or other recognized entity or person licensed to provide **Hospital**, or **Medical Services** to **Members**.

- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
- **Referral**. Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
- **Respite Care**. Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.
- **Serious Mental Illness**: means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- **Service Area**. The geographic area, established by **HMO** and approved by the appropriate regulatory authority.
- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.

- **Skilled Nursing Facility**. An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.
- **Specialist**. A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Subscriber**. A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the **Premiums** section of the **Group Agreement**.
- **Totally Disabled or Total Disability**. A **Member** shall be considered Totally Disabled if:
  1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
  2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.